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July 1956

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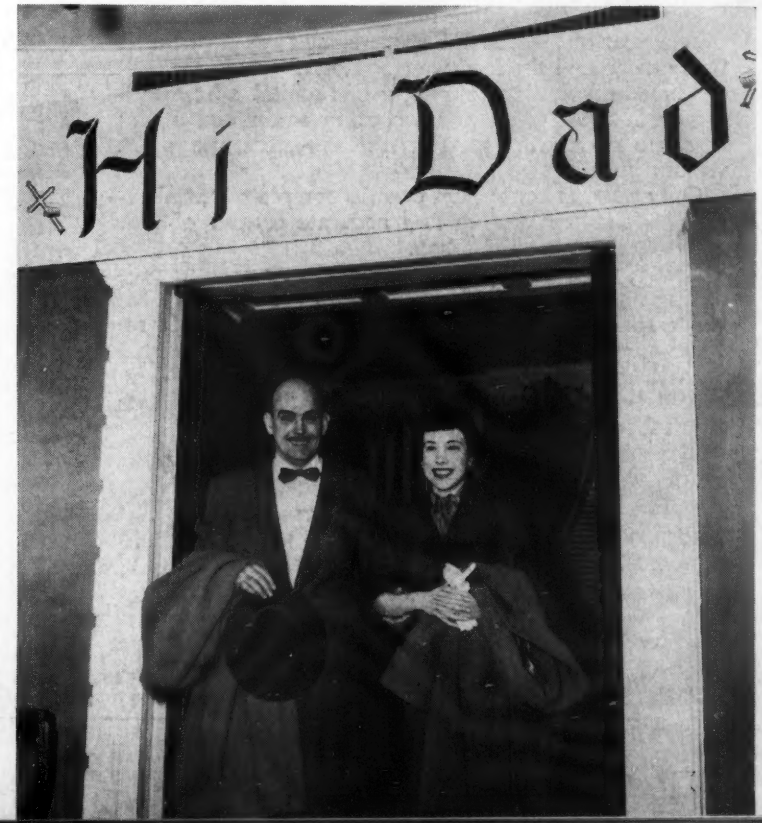
HOSPITAL **Management**

THE JOURNAL OF HOSPITAL ADMINISTRATION



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THE HINSDALE SANITARIUM AND HOSPITAL FINDS MEALPACK FOOD SERVICE ELIMINATES FOOD TEMPERATURE PROBLEMS

Student Nurse Ira Hansen serves a Mealpack Meal to patient at Hinsdale Sanitarium and Hospital, Hinsdale, Ill.

"Mealpack has completely eliminated patients' food complaints..."

"As a matter of fact, the only complaint we've had in over a year of Mealpack Service came from a pediatric patient. He said the food was too hot..."

These and similar comments of hospital administrators from coast to coast are proving again and again: NOTHING PROTECTS FOODS LIKE MEALPACK'S EXCLUSIVE VACUUM SEAL.

Only a MEALPACK system permits complete centralization of food preparation and accurate control of tray assembly in *one* main kitchen.

Costly, noisy floor pantries become new revenue producing floor utilities and valuable bed areas.

Mealpack speeds food service—and costs less. It reduces personnel. It cuts raw food costs—reduces wasted or uneaten food.

And best of all—Mealpack ends patient complaints about food temperature!

WRITE us for the complete Mealpack story and for a list of installations near you

Our Engineering Department is ready to show you how a Mealpack installation in Your hospital can earn $150-per-bed-per-year benefits—or more!

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Nothing protects food after preparation like Mealpack's exclusive vacuum seal.

Mealpack's inner, pre-heated Pyrex Brand Dish keeps meals piping hot up to 2 hours after packing. Maintains ideal, savory food temperature, moisture and color for up to 30 minutes after opening.

These 4 basic units make-up each Mealpack system

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MEALPACK INFRA-RED DISH HEATER

MEALPACK MULTI-DUTY TRAY SETTING TABLE

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HOSPITAL Management

A Clissold Publication

July 1956 Volume 82 Number 1

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TOMAC GOWNS ARE UNEXCELLED

All staff gowns are made of selected Jean Twill greige goods—the highly absorbent, long-wearing material that retains its shape after laundering. Sanforized to shrink only 1% maximum. Thread count 96 x 64, 2.85 yds. per lb. In white, misty green, or jade green—vat-dyed and color-fast.

Double-duty Nurse's Gown. As an O-R or general-use gown, it's designed for smart form-fitting coverage and ease of movement. Fastens easily with one unbreakable, mangle-proof button. Rounded V-neck with trim line collar and attached cuff sleeves with no raw hems. Tunnel belt is bar-tacked to eliminate repairs.

Operating Gowns with over-lap design. Wide over-lap from collar to hem keeps the back completely covered—without open tape-gaps. Cut extra full, particularly across the chest, with raglan sleeves for freer action. Extra-long, double-fold stockinette cuffs retain glove-like fit indefinitely.

The Nurse's Gown that nurses prefer! This wonderful slip-over gown offers attractive styling and cool comfort—and it needs no mending! Exclusive metal tab closure fastens gown at neck, lies flat, and never requires repair. Complete freedom of arm movement—with under-arm insert providing full coverage.

Write for American's Special July

Soft Goods Flyer!

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Suppliers of more than 15,000 products, hospital-proved for quality, efficiency and economy

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IN ENDURING COMFORT AND FREEDOM OF MOVEMENT—

They're guaranteed to exceed Federal Specifications

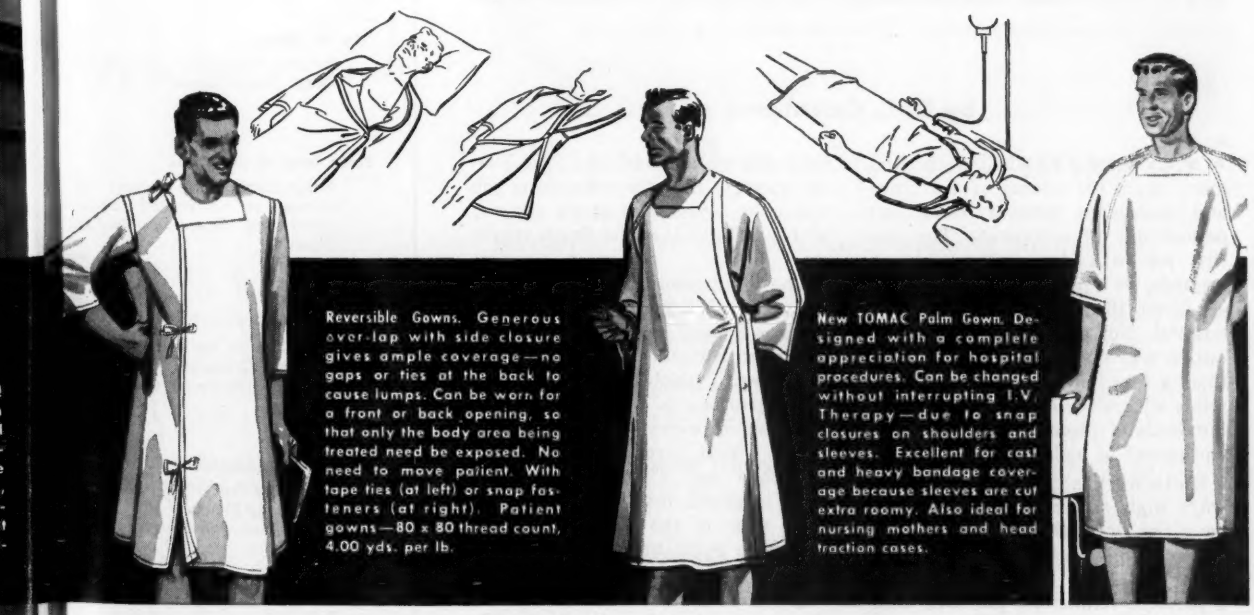
AFTER WASHING!

When you specify TOMAC Gowns, you insure the *utmost* comfort for your patients and staff members—and you realize maximum operating economies! *TOMAC gowns cost no more than ordinary gowns, and they are unsurpassed in length of service.*

The enduring and superior qualities of TOMAC gowns are the result of constant adaptation to ever-advancing medical techniques and hospital methods.

As you will see below, no detail has been overlooked in producing gowns that merit the famous TOMAC symbol—always your guarantee of superior quality, service, and economy.

Judged by any standards—for comfort, service, and economy—TOMAC gowns are superior!



Reversible Gowns. Generous over-lap with side closure gives ample coverage—no gaps or ties at the back to cause lumps. Can be worn for a front or back opening, so that only the body area being treated need be exposed. No need to move patient. With tape ties (at left) or snap fasteners (at right). Patient gowns—80 x 80 thread count, 4.00 yds. per lb.

New TOMAC Palm Gown. Designed with a complete appreciation for hospital procedures. Can be changed without interrupting I.V. Therapy—due to snap closures on shoulders and sleeves. Excellent for cast and heavy bandage coverage because sleeves are cut extra roomy. Also ideal for nursing mothers and head traction cases.

American Hospital Supply corporation

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For more information, use postcard on page 113.

Small Hospitals' Clinic

Portable Refinishing Service

Save time, motion and money

Semi-trailer in which refinishing is done on parking lot.

by D. C. Calcaterra

■ BUTTERWORTH HOSPITAL refinished more than 100 rooms of furniture and equipment without losing one patient day of occupancy. The entire job was done right on our grounds, in a portion of the parking area, not 100 yards away from the hospital. Not a single piece of furniture was out of service for more than a few hours. Like many hospitals with older equipment, we had hundreds of pieces of furniture and equipment in bad shape.

Butterworth's occupancy is always high and over the years we have not been able to sacrifice the loss of available beds, and the revenue that such loss entails, to do a periodic refinishing job. Our beds and tables were scarred, chipped, and ugly; any resemblance to the original finish had long since gone. Today, after refinishing, they look like they did when they first came from the factory. And the refinishing job was over a year ago so we can say with certainty that the finish stands up.

The equipment they use is portable. All of the refinishing equipment is housed in two semi-trailers, one that furnishes the power and the other in which the work is done. The furniture is first sand-blasted to remove every bit of existing paint. Next, rough spots are smoothed out. Then it is sprayed with a prime coat and baked-on. Last step is the enamel coating, baked-on in an infrared oven, then cooled.

We had an almost unlimited choice of colors for the finish. We could have any color we wanted on any equipment we wanted. Since they worked within shouting distance, if we changed our minds, the change was made—just like that! Here is a list of the equipment we had refinished in this novel way:

Please turn to page 21

Mr. Calcaterra is assistant director at Butterworth Hospital in Grand Rapids, Michigan.

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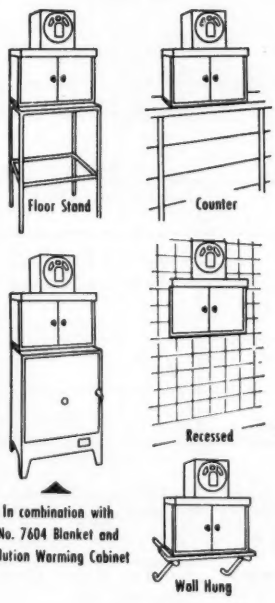
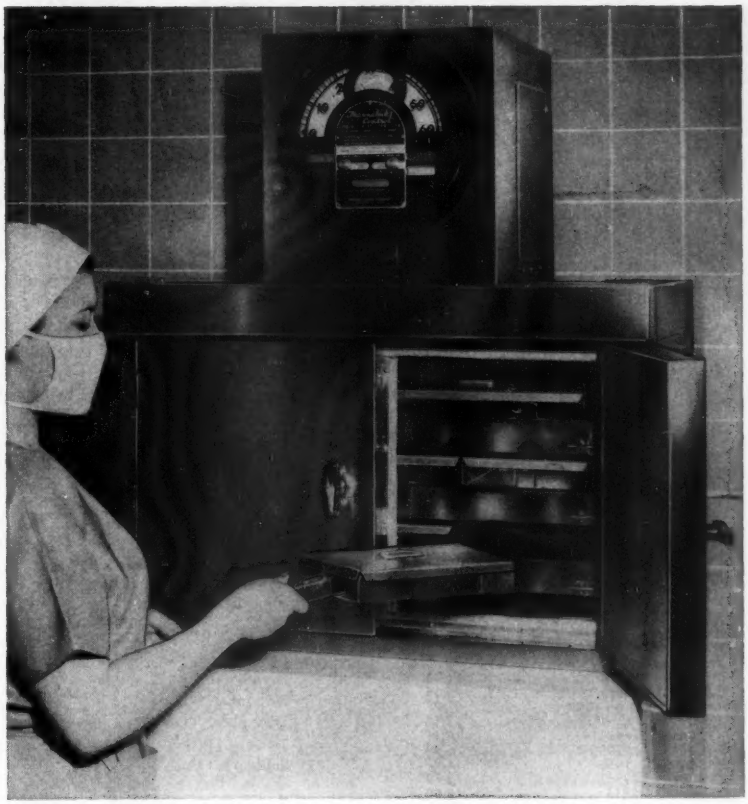
All-Killing Electric Heat in new Glass Shelving Gives Positive Sterilization

New Dry Heat method uses radiation and contact to save all delicate edges

5 AVAILABLE MOUNTINGS FOR SELECTION



WRITE TODAY for technical literature and specifications



CASTLE NO. 4 RADIANT ENERGY STERILIZER

Will automatically process cutting instruments for 9 surgical cases simultaneously . . . insures additional supply for emergency requirements.

1 Safeguards technique — guarantees correct factors of temperature and time beyond all question or doubt.

2 Safeguards against rust and corrosion — which may result when sharp instruments are sterilized by moist heat.

3 Safeguards against sediment — which accumulates in irregular surfaces, joints, and needle lumens when certain chemicals and detergents are used.

CASTLE'S THERMALOCK CONTROL SYSTEM electromatically controls each successive phase of the sterilizing cycle . . . automatically recycles if time-temperature exposure period is interrupted . . . impounds load until cycle is completed.

WILMOT CASTLE CO.
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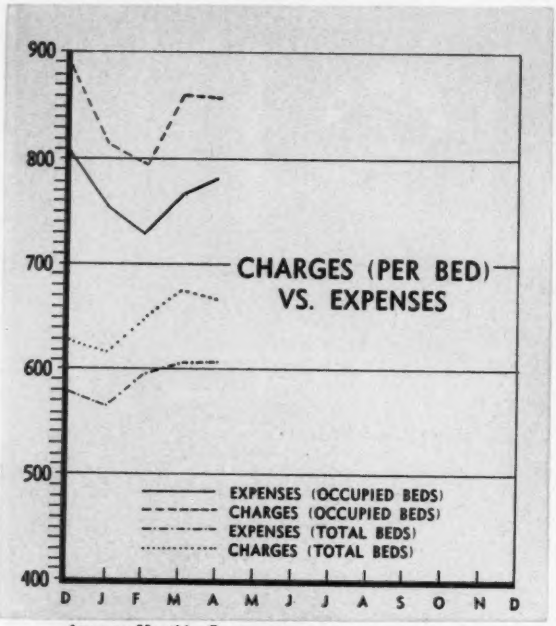
How's Business

with the American Association of Hospital Accountants



■ THE DIVERSITY in administrative practices of most hospitals was revealed last month in answer to the question, "What department has responsibility for reporting the number of days of patient care?" Approximately 82 percent of the replies were divided evenly between the business office and the medical records department. Several replies indicated that both departments were equally responsible with no sharp division of responsibility between them. A further 12 percent of the replies fixed responsibility upon the admitting department and a few replies involved all three of the departments mentioned above. Other departments mentioned infrequently in the replies were the administrator's office, the nursing department, the accounting department and the census office. Final results were as follows:

Admitting Department	12%
Business Office	41.5%
Medical Records	41%
Miscellaneous	5.5%

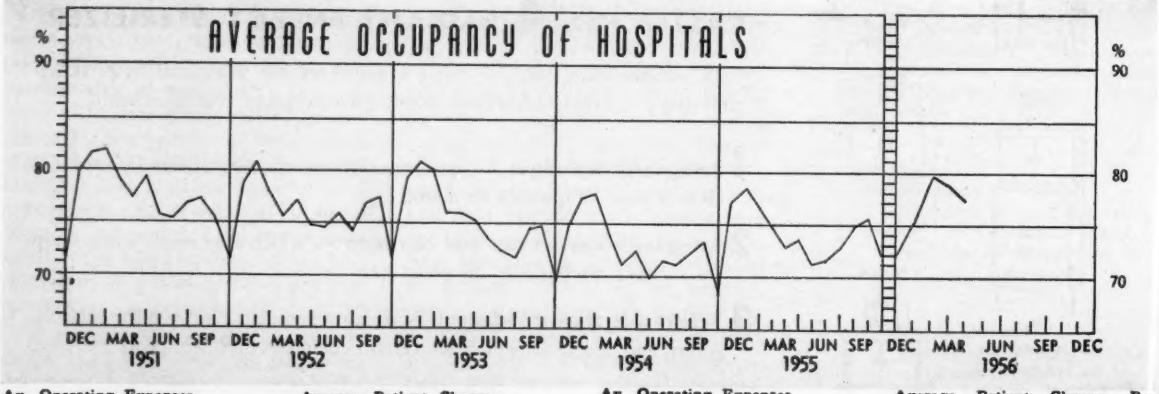
There was no regional significance. ■

Average Monthly Occupancy (on 100 per cent basis)

September 1954	70.79
October, 1954	71.76
November, 1954	73.19
December, 1954	67.78
January, 1955	77.10
February, 1955	78.45
March, 1955	76.90
April, 1955	74.70
May, 1955	72.70
June, 1955	73.08
July, 1955	72.29
August, 1955	71.93
September, 1955	72.06
October, 1955	74.74
November, 1955	75.57
December, 1955	71.64
January, 1956	75.09
February, 1956	79.68
March, 1956	78.52
April, 1956	77.57

Average Length of Patient Stay (in days)

September, 1955	6.7
October, 1955	7.0
November, 1955	6.8
December, 1955	6.7
January, 1956	6.7
February, 1956	6.9
March, 1956	7.0
April, 1956	6.9



Av. Operating Expenses Per Occupied Bed Per Month

November, 1954	768.72
December, 1954	802.38
January, 1955	710.74
February, 1955	694.49
March, 1955	760.69
April, 1955	753.67
May, 1955	776.15
June, 1955	758.23
July, 1955	778.99
August, 1955	781.38
September, 1955	770.05
October, 1955	744.00
November, 1955	741.55
December, 1955	806.66
January, 1956	750.40
February, 1956	727.77
March, 1956	761.15
April, 1956	781.64

Average Patient Charges Per Occupied Bed Per Month

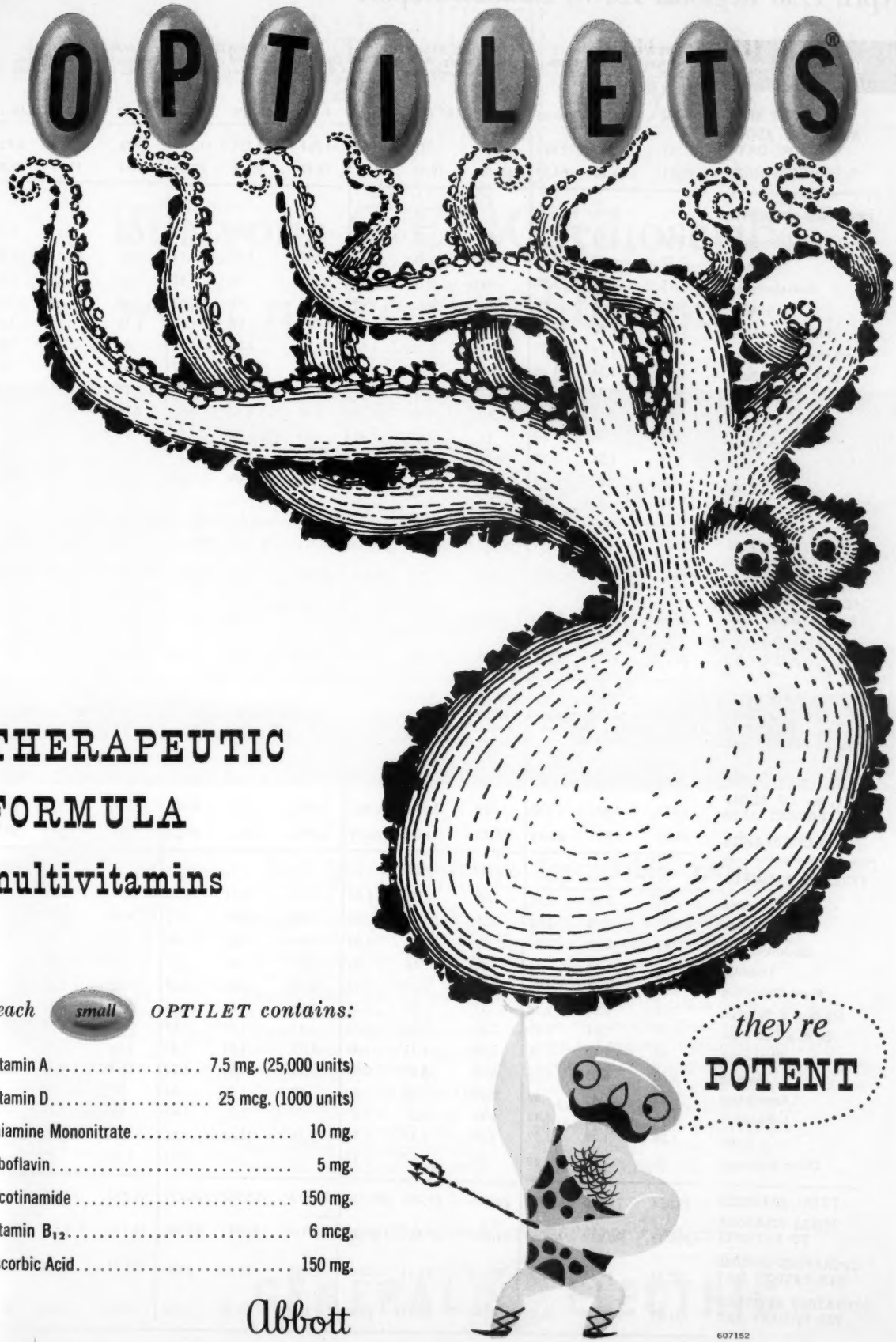
November, 1954	797.85
December, 1954	812.01
January, 1955	781.90
February, 1955	741.93
March, 1955	832.35
April, 1955	810.71
May, 1955	852.00
June, 1955	806.73
July, 1955	832.30
August, 1955	840.93
September, 1955	820.97
October, 1955	815.82
November, 1955	810.10
December, 1955	881.58
January, 1956	817.99
February, 1956	798.13
March, 1956	853.22
April, 1956	857.60

Av. Operating Expenses Per Bed Per Month (Total Beds)

November, 1954	561.90
December, 1954	545.02
January, 1955	547.39
February, 1955	545.16
March, 1955	585.64
April, 1955	563.51
May, 1955	563.59
June, 1955	555.43
July, 1955	562.07
August, 1955	561.22
September, 1955	561.84
October, 1955	556.56
November, 1955	569.55
December, 1955	579.23
January, 1956	566.58
February, 1956	590.55
March, 1956	601.63
April, 1956	605.30

Average Patient Charges Per Bed Per Month (Total Beds)

November, 1954	583.02
December, 1954	550.70
January, 1955	602.09
February, 1955	582.20
March, 1955	640.31
April, 1955	609.04
May, 1955	620.03
June, 1955	591.87
July, 1955	599.42
August, 1955	604.51
September, 1955	594.01
October, 1955	608.14
November, 1955	620.28
December, 1955	629.89
January, 1956	618.81
February, 1956	646.11
March, 1956	672.66
April, 1956	663.13



For more information, use postcard on page 113.

April 1956 Regional How's Business Report

REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,753	3,482	9,823	909	3,328	8,983	1,761	4,174	11,204	1,328	3,676	8,929
% of OCCUPANCY	75.51	81.20	84.59	66.70	78.46	86.31	76.57	83.66	80.04	63.43	73.71	83.81
EXPENSES BY DEPTS.	Per Patient Day						Per Patient Day					
Administration	2.62	3.44	3.73	2.89	2.53	2.95	2.17	2.20	2.37	2.86	2.17	2.75
Dietary	3.72	4.05	4.21	2.73	2.75	3.63	2.39	3.17	3.13	2.91	2.74	2.80
Housekeeping	1.25	1.51	1.90	.94	1.16	1.26	.87	.96	1.10	1.03	.85	1.11
Laundry	.72	.64	.52	.51	.51	.52	.66	.37	.60	.64	.38	.42
Plant Operation	2.04	1.90	2.53	1.74	1.57	1.80	1.22	1.54	1.63	1.76	1.19	1.41
Medical & Surgical	.79	1.24	1.87	1.13	1.13	1.57	1.45	2.08	1.94	.93	.81	1.58
O. R. & Del. Rms.	1.34	1.58	1.58	1.40	1.34	1.11	1.10	1.38	1.47	1.43	1.37	1.94
Pharmacy	1.10	1.21	.98	.60	.87	.88	1.05	.70	1.24	1.60	1.47	1.79
Nursing	5.97	6.65	5.18	5.60	5.79	5.29	4.64	4.61	5.83	6.26	4.96	4.76
Anesthesia	1.15	1.05	.60	.61	.59	.43	.66	.37	.46	.87	.55	.77
Laboratory	1.38	1.56	1.77	1.38	1.37	1.26	.84	1.16	1.35	1.42	1.25	1.52
X-ray	1.68	2.03	1.32	1.02	1.32	1.07	1.11	1.09	1.08	1.31	1.35	1.34
Other expenses	.26	.96	.93	.39	.42	1.06	.49	.36	1.61	.51	1.08	.78
TOTAL EXPENSES	42,371	97,256	276,652	18,501	68,555	208,341	30,822	82,599	272,247	30,739	75,279	209,385
TOTAL CHARGES TO PATIENTS	43,555	103,590	282,245	20,784	76,126	235,561	38,288	91,827	299,463	30,043	83,359	239,449
OPERATING INCOME PER PATIENT DAY	24.85	29.75	23.73	22.86	22.87	26.22	21.74	22.00	26.73	22.63	24.04	26.82
OPERATING EXPENSES PER PATIENT DAY	24.17	27.93	28.16	20.35	20.60	23.19	17.50	19.79	24.30	23.15	20.48	23.45

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,307	3,515	8,940	1,020	3,954	10,402	1,191	3,072	8,010	1,627	3,371	6,726
% of OCCUPANCY	69.05	79.43	85.29	67.73	81.94	84.18	62.90	70.22	85.03	74.71	72.73	87.54
EXPENSES BY DEPTS.	Per Patient Day						Per Patient Day					
Administration	1.97	2.21	3.05	2.09	2.02	3.07	2.25	2.31	2.20	3.55	3.87	4.14
Dietary	2.97	2.78	3.58	2.39	3.24	3.74	2.50	3.08	2.92	3.60	3.70	3.35
Housekeeping	.97	1.20	1.71	.72	1.21	1.29	.68	1.05	.93	1.53	1.54	1.54
Laundry	.61	.54	.93	.57	.55	.52	.69	.59	.41	.87	.69	.67
Plant Operation	1.56	1.52	2.34	1.49	1.68	2.11	1.70	1.40	1.47	1.63	1.71	2.15
Medical & Surgical	1.17	2.34	2.78	.97	.76	1.11	2.28	.89	1.08	1.71	1.99	1.88
O. R. & Del. Rms.	1.25	1.51	1.43	1.41	1.70	1.75	1.41	1.94	1.68	2.76	2.59	1.98
Pharmacy	.94	1.20	1.08	2.20	1.21	1.44	1.95	1.43	1.32	1.66	1.53	1.43
Nursing	6.70	6.03	7.21	5.48	4.62	7.04	5.93	6.52	6.20	9.73	8.55	8.37
Anesthesia	.62	.43	.62	.20	.24	.90	.85	1.38	.24	.82	.62	.49
Laboratory	1.16	1.30	1.48	1.22	1.27	1.67	1.07	2.21	1.63	1.66	1.90	2.39
X-ray	1.58	1.29	1.37	1.60	1.23	1.23	1.25	1.60	1.25	1.81	1.59	1.72
Other expenses	.36	.58	.88	.50	.67	.42	.52	.52	1.07	1.30	.95	2.56
TOTAL EXPENSES	27,854	77,450	252,424	20,334	82,094	283,727	24,518	78,387	176,731	52,277	104,522	218,740
TOTAL CHARGES TO PATIENTS	29,703	90,232	270,062	21,605	89,391	317,188	28,033	90,493	188,300	58,131	111,572	230,634
OPERATING INCOME PER PATIENT DAY	22.73	25.67	30.21	21.18	22.61	30.49	23.58	29.46	23.51	35.73	33.10	34.30
OPERATING EXPENSES PER PATIENT DAY	21.31	22.03	28.24	19.94	20.76	27.28	20.59	25.52	22.06	32.13	31.01	32.52

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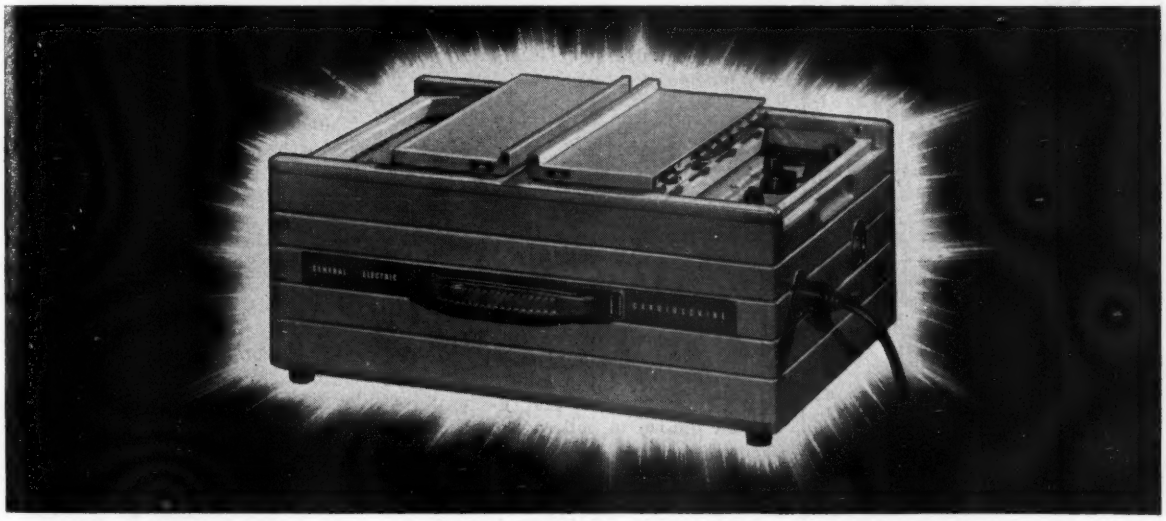

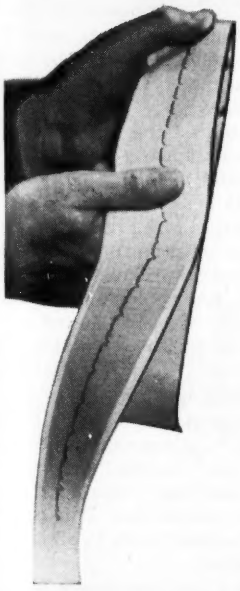

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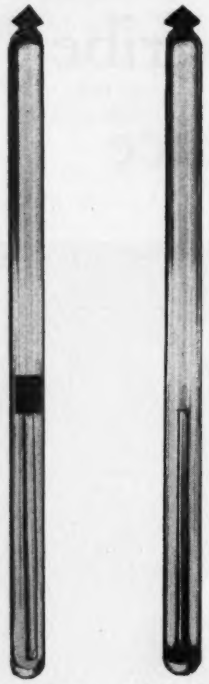

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Hospital Accounting

with Professor T. LeRoy Martin

Bad Accounts — Cost or Reduction In Gross Revenue?

Inquiry: *Why is loss on bad accounts of a hospital deducted directly from gross revenue from patients on the statement of income and expense, while in private commercial enterprises, the loss on bad accounts is almost always treated as an expense in the income statement?*

Comment: The difference in the treatment of the loss on bad accounts is not the result of the difference in organization and operation of a hospital as compared with a commercial business, but rather the application of a different theory by those responsible for formulating uniform accounting procedures for hospitals. The theory applied to hospital accounting is that the cost of service rendered is shown among the expenses and that if the loss from failure to collect a receivable covering those services is also included among the expenses, the result is a double charge in the expense section. Therefore, the loss is treated as a direct deduction from gross revenue in the statements leaving a net amount representing net collectible revenue. Many accountants believe that the same principle should be applied to commercial accounting.

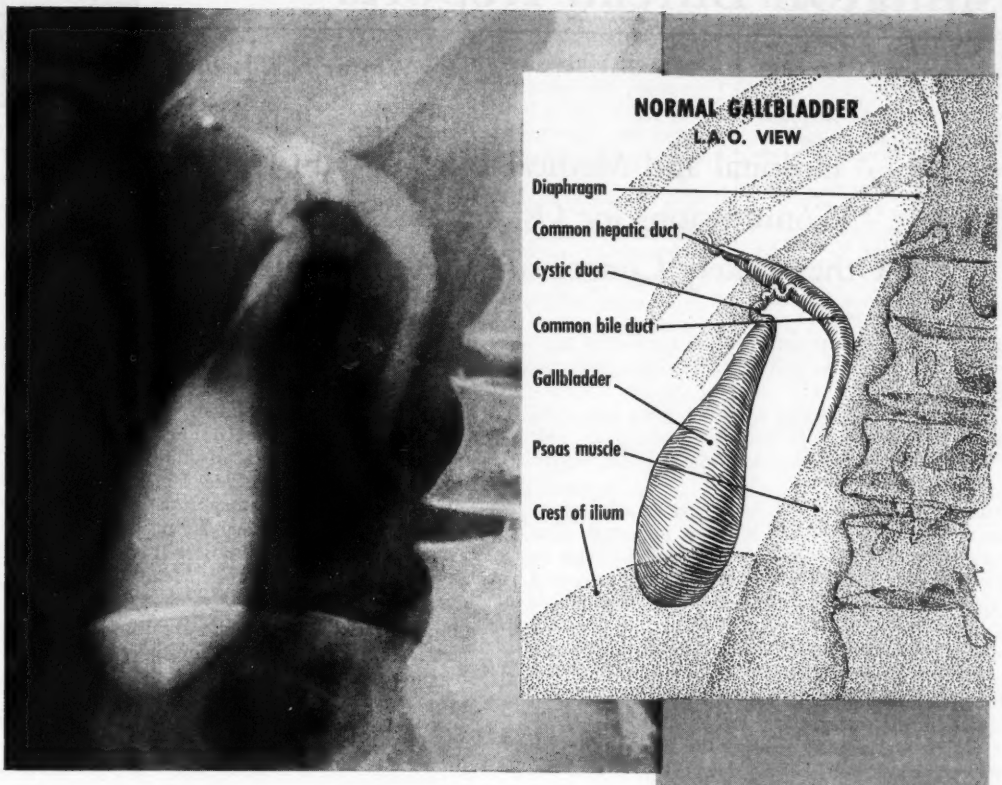
The theory which is applied in the greater number of instances in commercial and industrial accounting is that income is earned regardless of whether it is collected, and that a reduction of gross revenue by the amount of uncollectible accounts understates gross earnings. The proponents of this theory are not concerned about the argument of a double charge among the expenses. Their argument is that the cost of materials sold or services rendered is one cost and that the loss on bad accounts is an entirely different type of item, *i. e.*, the loss of an asset (a receivable) which was acquired when the income was earned.

The important consideration is not the theory, but rather the adoption of uniformity in procedure for purposes of securing comparable operating data. Incidentally, the accepted procedure for hospital statements in Great Britain requires the loss on bad accounts to be treated as an expense—not as a reduction in gross revenue on the income and expense statement.

Inquiry: *What are some of the advantages to be derived from the use of a uniform system of accounting in hospitals?*

Comment: To secure complete uniformity in an accounting system and be able to obtain the advantages in connection with it, two kinds of uniformity are necessary. First, the classification of accounts must be uniform, and, secondly, there must be uniformity in the allocation of all costs and expenses to the individual accounts in the classification. This requires a complete understanding of the type of expenditure chargeable to each account by bookkeeping department employees in each institution using the uniform system. Given complete uniformity, the advantages are many. A few of them are listed below:

1. All items on the statement of income and expense can be compared with similar items on statements of other hospitals and with averages of individual items for a selected group of hospitals. This procedure provides information for proper administration and control of operations. Areas of operation in which a particular hospital varies from the usual are immediately apparent.
2. Financial statements of a hospital may be compared with those of the same hospital for other periods with assurance that the items are comparable. This comparison reveals trends in all areas of operation.
3. Use of a uniform system facilitates acceptance by reimbursement agencies of statements of service rendered. ■



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Buckstein, Jacob: The Digestive Tract in Roentgenology. Philadelphia, J. B. Lippincott Co., 2nd ed., 1953, vol. 2, p. 1003.

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Washington Bureau Reports

by Walter N. Clissold

Hospital and Medical Bill Log-Jam Cracks
Commissions for Osteopaths Seem Certain
Other Likely Congressional Action Pin-pointed

■ LOOKS AS IF the hospital and medical legislative log-jam is cracking. There is considerable Congressional action to report.

At press time favorable House votes were expected on research grants, medical school construction aid, sickness and disability survey, and the mental health bill.

Legislation authorizing the commissioning of doctors of osteopathy was well on its way to approval. The military dependents care bill also was much closer to completion, having passed the Senate in mid-May, and gone to conference with the House to iron out differences.

Liberalizing of social security, however, was still being haggled over.

Hill-Burton extension is bottled up over fear it will get involved in the integration issue. *And,* the U. S. Chamber of Commerce is suggesting the whole program be extensively reviewed before breathing more life into the Act. If there is not action on this score H-B will continue (its current life runs to July 1, 1957), but it's not difficult to visualize possible implications to long-range planning.

Other presumably sure items are the establishment of the National Library of Medicine; medical care for those receiving public assistance; aid to practical nursing; and the federal employees health insurance.

Now, for some of the major details:

• The *military dependents health care bill* now seems to answer most of the criticism which had earlier been levelled at it, even though it may not completely satisfy everyone. In essence, it unifies the kind of medical care dependents can get; authorizes the Secretary of Defense to negotiate insurance contracts; allows dependents choice between military and civilian facilities, except where dependents are domiciled on a post where military facilities are available. On the principle objection — that the legislation would permit building of a medical hierarchy in the military, point was made during Senate debate and covered in the committee report, that any proposal to, for example, build added military hospitals, would require coming back to Congress for authorization. At such a time, presumably, Congress could turn thumbs down.

• Marriage of the *research grants* and *aid to medical schools* bills never came off. Reason is related to the problems holding up H-B extension. However, it is still believed likely that some form of federal aid to medical research and construction and equipping of research facilities at medical schools will be passed before adjournment. Bills implementing both ideas had progressed through the House under prodding from Rep. J. Percy Priest.

• *Military commissions for doctors of osteopathy* seems next to certain. Both House and Senate have enacted legislation. The Senate version, however, is enough different to have to go back to the House. Particular emphasis is placed in the Senate amendment on osteopaths who are "qualified." Five qualifications are spelled out, including recommendation for appointment by the Surgeon General of one of the three services. It should be noted that this legislation is "authorizing only," and not "mandatory" upon the Secretary of Defense. The three military services will be free to determine to what extent they will participate in the plan. administered by the Public Health Service of the De-

• *National Library of Medicine* looks as if it will be administered by the Public Health Service of the Department of Health, Education and Welfare. A Board of Regents would be appointed by the President. Bills were entered by a squad of Illinois Congressmen to locate the Library in Chicago. Doubtful possibility, however, it's believed.

• *Federal payments for medical care* for those on public assistance rolls, as bill now stands, would be available for 1) the blind, 2) aged, 3) totally and permanently disabled, and 4) dependent children. AHA has urged that it be broadened, to cover all public assistance recipients.

• *Alaska Mental Health* bill passage was expected momentarily. Wrangling over commitment procedure was finally settled by decision to leave this question up to Territorial authorities.

• *Veterans' benefits* which, if the recommendations of the President's Commission on Veterans Pensions were adopted, would be greatly scaled down, probably won't be touched in this election year. Report of the Commission, headed by Gen. Omar N. Bradley, in fact, has been rather roundly criticized by vote-conscious Congressmen. Next year, after the heat of election battle has subsided, the report may get a more dispassionate look-see. Particularly, the Commission was outspoken in its opposition to increased VA health services for non-service connected disability. Number one guiding principle recommended by the Commission was that military service is an obligation of citizenship and not, in itself, justification for special benefits.

• Secretary of Labor Mitchell in an "Open Letter to Graduates," has classified employment opportunity in the health professions as "excellent." "Shortage of medical personnel," expected to continue "for several years," as well as expanding population, rising income level, and "better education on the need for medical care," were some of the reasons given for the bright outlook.

• Navy is asking Selective Service System to supply 380 M. D.'s during July.

• Federal Hospital Council met May 28th; the Research Study Section, May 17-18. ■

SMALL HOSPITAL CLINIC

Continued from page 8

195 beds
190 Bedside cabinets
74 Bassinets
62 Utility Tables
21 Chairs
20 Revolving Stools
10 Utility Carts
2 Examining Tables
28 Miscellaneous pieces

Ordinarily, we would not have been able to afford an ambitious job like this at any one time. The usual refinishing work is expensive. And then there is the shipping, the unloading, the harm to the hospital's service while the equipment is gone, and the very important item of lost hospital revenue. We estimated that it would take a full year to refinish our equipment by the usual methods. This new method took only six weeks. The final cost was a fraction of any estimate we had ever had. That is why we went ahead.

Butterworth Hospital has just completed a 4½ million dollar expansion program, increasing the bed complement to 430 beds and 70 bassinets. We are extremely proud and happy with the new buildings and its furnishings and it put the older building and its equipment to shame. That was *before* we had the refinishing done. No wonder we're enthusiastic! ■

A.H.A. Announces Policy On Health Insurance For Federal Employees

■ THE AMERICAN HOSPITAL ASSOCIATION favors a health insurance system on a payroll deduction basis for Federal employees to make the Federal career service more attractive and to promote the efficiency of its administration.

It concurs in principle with the recommendations of the second Hoover Commission that "the executive branch develop a voluntary contributory program of medical care and hospital insurance to be conducted through a pool of private health insurance agencies for all the civilian employees of the Federal government on a prepayment basis and using payroll deductions."

The Association notes that the Executive Department has recognized that it has a responsibility in this area and has proposed providing "major medical" health insurance coverage for Federal employees without cost to those employees, as a step toward helping its employees meet the costs of illness. The Association believes that this is not enough.

It believes that all concerned should recognize that this proposal deals only with costs of the so-called catastrophic illnesses and ignores the more important question of basic coverage of the overwhelming number of illnesses which strike our people.

The Association believes that Federal employees should have the opportunity to cover those basic costs through a voluntary prepayment plan and through a payroll deduction system.

The Association will continue to support sound basic coverage for the costs of illness among Federal employees through payroll deduction. It does not believe that this large group of American employees should be denied a benefit now enjoyed by so many other American workers. It does not believe, as apparently the Civil Service Commission does, that payroll deduction in the Federal establishment is such an insoluble administrative problem that it justifies a denial of such a basic benefit. ■

Plan Hospital Administration Program in Australia

■ SUPERINTENDENT GERHARD HARTMAN of the State University of Iowa Hospitals will act as consultant for six weeks this summer in the planning of an educational program in hospital administration at Australia's New South Wales University of Technology. His work will be sponsored by the W. K. Kellogg Foundation.

Dr. Hartman also will serve in an advisory capacity to the Australian Hospital Association, the Australian Institute of Hospital Administrators, the University of Sydney's college of medicine and the Australian government.

Hartman, who is professor of hospital administration at the State University of Iowa, was invited to assist the Australian groups in the development of a new graduate program in hospital administration. The invitation came from J. P. Baxter, vice-chancellor of the New South Wales University of Technology.

The State Board of Regents has granted the administrator a leave of absence in which to make the trip.

Last year the Kellogg Foundation awarded a $96,000 grant to the State University of Iowa for use in the hospital administration program which Professor Hartman directs. ■

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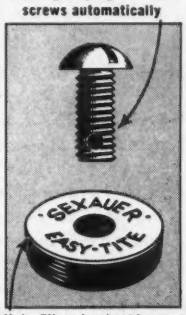

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Consulting

with Dr. Letourneau

Examination of Medical Records

QUESTION: *I believe that an individual patient should be shown his record, if he gives us written authorization. My reason for saying this is that the information contained in the record is the personal property of the patient.*

ANSWER: The record maintained by the hospital is for the purpose of keeping itself informed of the services rendered to the patient on its premises. Some of the information concerns the professional relationship between doctor and patient while on the hospital premises.

There is also much information that is not confidential and is maintained for the benefit of the hospital administration, which is no concern of the patient.

The patient has no inherent right to examine his own record, nor do any of his representatives. The medical records are the business records of the hospital and should be treated confidentially in the same way as any other business records. I do not know of any other business organization that throws open its records or its books to its customers at the whim of the latter.

Hearing Clinics

QUESTION: *Can you advise me where to refer patients with hearing difficulties?*

ANSWER: The American Medical Association advises that information about hearing clinics may be obtained by writing to the Audiology Foundation, Box 21, Glenview, Illinois.

Witness Fees

QUESTION: *What is your opinion concerning the retention of the witness fee by the Medical Record Librarian when she testifies in court?*

ANSWER: The witness fee should be turned over to the hospital. The Medical Record Librarian is not being called or subpoenaed personally for testimony on her own behalf. She is being called on behalf of the hospital which is the official custodian of the medical records.

During her attendance at court, her salary is paid by the hospital. Transportation to and from the courtroom is paid for by the hospital. In effect, she is being loaned to the court by the hospital. Since the hospital bears the expenses, it is only reasonable that the hospital should receive the remuneration.

Conversely, if the medical record librarian is permitted to retain the witness fee, there would be no reason why her salary should not also be deducted for her time in attendance at court. It would also be fair to expect her to defray her own expenses in going to court.

Thus, the witness fee should be turned over to the hospital, but any expenses involved in going to court should be borne by the hospital. This should include transportation to and from the court and meals during waiting time. To quote an old adage, "You cannot have your cake and eat it."

Frequency of Trustee Meetings

QUESTION: *How frequently should the Board of Trustees meet?*

ANSWER: At least once a month.

Self-Medication

QUESTION: *We are experiencing a shortage of personnel at the present time and one of the suggestions made by our physicians is that patients should be permitted to administer their own medicines. What do you think of this practice?*

ANSWER: There is no categorical reply to this question. Some patients are undoubtedly benefitted by self-medication. A cardiac patient, for example, who has access to an oxygen source may relieve himself of an impending attack. An asthmatic patient may sense the onset of an attack which he can abort by taking medication promptly. An anginal patient can similarly relieve his pain with a small tablet of nitroglycerine.

However, there are other patients who should not be permitted to medicate themselves. Patients who are on sedation, taking hypnotics and narcotics, patients who are taking dangerous drugs, such as *dicoumarol* or patients on hormone therapy should similarly not medicate themselves.

You might recommend to your pharmacy committee consideration of the multiple dose capsules manufactured by some drug companies while they are considering what policies should be adopted for self-medication.

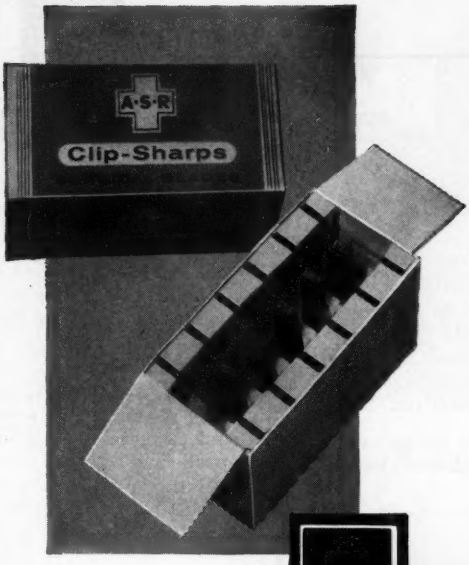
Patients "On Leave"

QUESTION: *Our general hospital has recently opened a psychiatric wing. The physicians treating patients in this service frequently allow patients to go home "on leave" over weekends. This has created problems in our accounting department. It also raises the question of our liability. Could you advise us what is the practice in other hospitals?*

ANSWER: There are two ways of handling this problem. One way is to discharge the patients on Friday and readmit them on Monday. This makes for a lot of extra work in the admitting and accounting departments but it has the advantage of showing a short patient stay per admission and so helps to bring down the hospital's average. It also would tend to lessen the hospital's liability for such a patient but this is a matter of circumstance.

The second method is to carry the patient "on the books" but to make no charge for the room during the absence of the patient. This tends to show a high occupancy over weekends with corresponding saving in dietary food costs since these patients do not eat at the expense of the hospital during their absence.

The potential liability of the hospital for such a patient is not much more than under the first system. Although the patient is nominally a responsibility of the hospital, the fact that a psychiatrist has pronounced him fit and able to visit outside the hospital would tend to absolve the institution from responsibility for him. ■



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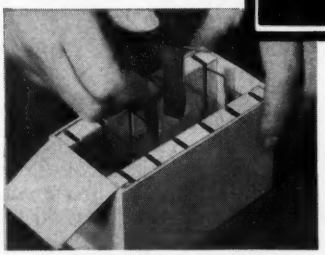

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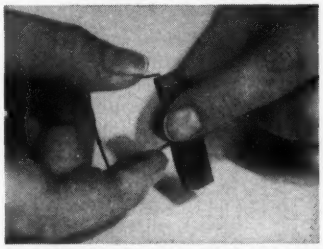
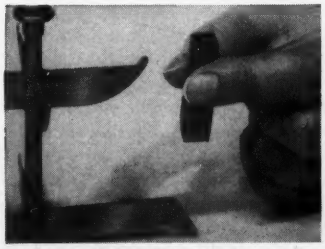


Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



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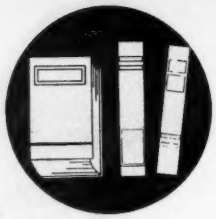


Sheltered care for older persons — standards and suggestions;

Published by the Board of Hospitals and Homes of the Methodist Church, 740 Rush Street, Chicago 11, Illinois. Copyright 1955.

■ THIS EXCELLENT LITTLE BOOK lays down, in outline form, some of the broad, flexible principles of organization for nursing and convalescent homes, within the framework of the organization of the Methodist Church.

However, the principles covered are of such general interest as to be an important addition to any one's library. It is divided into three main sections, the first of which is a very well organized review of the administrative aspect of sheltered care.

The second section covers suggested forms of Articles of Incorporation, By-Laws, Rules and Regulations for a Home for Older Persons.

The last section contains a number of suggested steps of procedure for admission and a list of forms and agreements that might be used in this type of an operation.

This book is timely. There is an increasing demand for patterns of sheltered care for older people and the excellence of this pattern is demonstration by the fact that the Methodist Church continues to be one of the leaders in this field. Very worth while reading and keeping on the reference shelf.

— *C. U. L.* ■

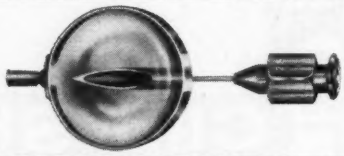
Detergents, What They Are and What They Do

Published by the Chemical Publishing Company, 212 Fifth Avenue, New York City. Price, $4.00.

■ THIS BOOK IS A presentation of the development of Detergents or "Cleaning Agents" and their application to both Industrial, Maintenance and Household cleaning. The opening chapter deals with the most common and best known detergent — Soap, its early history, chemical structure, manufacture, subsequent refinements and the addition of builders to add to its efficiency. It also explains methods of synthesizing certain compounds and explains their function as surface-active agents in loosening and emulsifying soil and holding it in suspension. Following chapters deal with the more widely known detergents and synthetics explaining the theories and action of emulsification, surface agents, dispersion of dirt particles, soil suspension, wetting agents etc. Various technical terms are explained and illustrated so as to be readily understood by the average person with little or no technical training. The pH scale of measurement of the intensity of the acidity or alkalinity of a solution is well defined. Bases and acids, both belonging to the class of substances known as "ionic" compounds are discussed. Hard water, its effect on soaps and synthetic detergents and on laundry washing procedures is well covered as are also methods and benefits of water softening.

Please turn to page 34

Visual inspection



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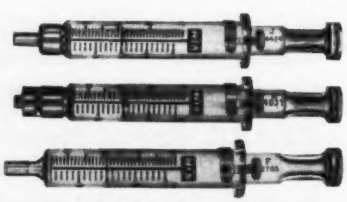

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1. Drill, V. A.: *Pharmacology in Medicine, McGraw-Hill Book Company, Inc., New York, 1954, p. 9/11.*

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Guest Editorial

by William C. Stronach

Executive Secretary
American College of Radiology
Chicago, Illinois

Responsibility — Authority = FRUSTRATION

DR. A. W. Snoke, President-elect of the American Hospital Association, has been quoted as telling a Midyear Conference of the Association:

> *"Offer the radiologist or pathologist twice as much as he is getting, and watch his opinions change."*

This is inaccurate. It is saddening that a man in the position of Dr. Snoke believes it to be true. The files of the American College of Radiology are replete with correspondence from radiologists who are well paid, but who still are frustrated employees of hospitals. These men are seeking independent practice status for the benefit of their patients. They are not trying to get "twice as much".

Dr. Snoke's statement illustrates that, while there has been much discussion of physician-hospital relationships, there has been an acute failure in communication. There has been listening without hearing. Worse, there has been simulated listening with ears and minds insulated from the other man's viewpoint and needs. Until hospital spokesmen and physicians truly communicate, there is not much hope of solving mutual problems.

To you involved in hospital administration, I make this plea: Attribute to physicians and their medical societies the same sort of unselfish motivation that you attribute to yourselves and hospital organizations. Even if we cannot always agree, let us accept as a fact that most physicians and most hospital administrators are truthful individuals who are trying to do the best possible job of caring for sick people.

Believe physicians of national stature when they tell you why they oppose employment by hospitals. Do not automatically impute to them venal motives.

When a radiologist is employed by a hospital, the decisions important to him as a physician, and important to his patients because of the effect these decisions have on the care he is able to give them, are being made by others. No non-radiologist member of the administration of the hospital can have the training and knowledge of the operation of an x-ray department, or of the effect upon patients of the various decisions that are made, yet the radiologist, the person best able to decide, is powerless to effect decisions. The decisions referred to involved necessary equipment, the number of associates needed to give full consultation service to the staff and adequate time to each examination, the number and competence of technicians needed and what must be paid to keep them from being hired away by privately practicing physicians. The radiologist must achieve independence in order to control the factors that, in turn, control patient care.

Men become physicians for a great variety of reasons, but certainly foremost amongst these is the desire to care for the sick. When a radiologist accepts a patient, he accepts the medical responsibility for that patient. He cannot escape it. When he accepts employment by a hospital that sells his services to patients, he lacks full authority to obtain the tools and assistance he believes to be needed in the best interests of his patients, and is thus frustrated. He is prevented from practicing at the top level of his capabilities.

This is not a plea for license. The legitimate interests of the trustees of the hospital, its administrative and medical staffs and the public must be protected, but this is not accomplished by holding the whip of employment over part of the medical profession. The radiologist, like all other physicians, is dedicated to the welfare of his patients. He feels that, to give the best service, he must have independence. Those in hospital administration wishing to develop a framework for radiologic practice that will result in a superior *patient* service are urged to consult with the American College of Radiology.

Here one can obtain basic concepts about radiological practice arrived at after mature deliberation away from the emotional background so frequently associated with contract negotiation. If all are guided by soundly grounded policies, patient service is improved and conflict disappears. ■

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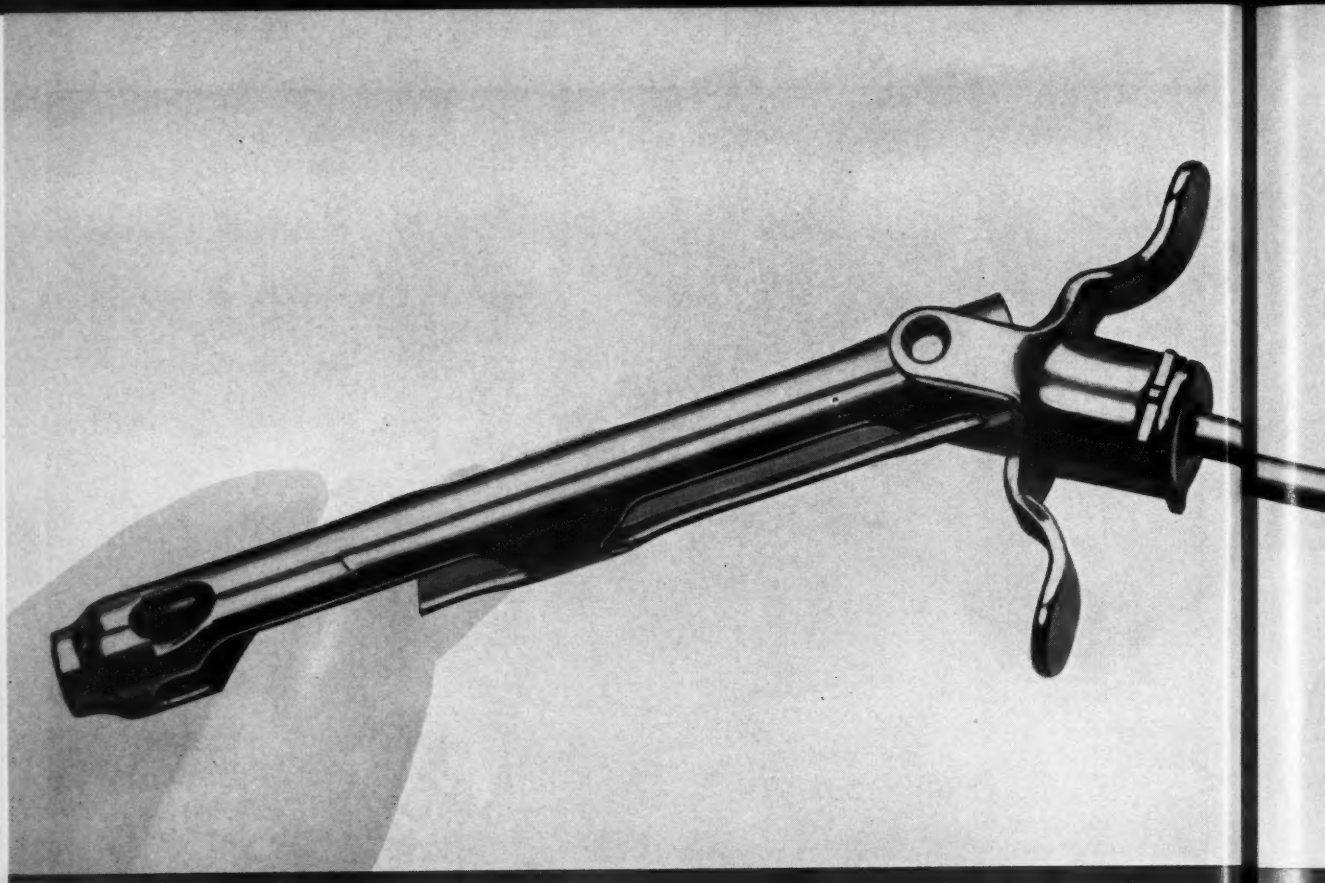

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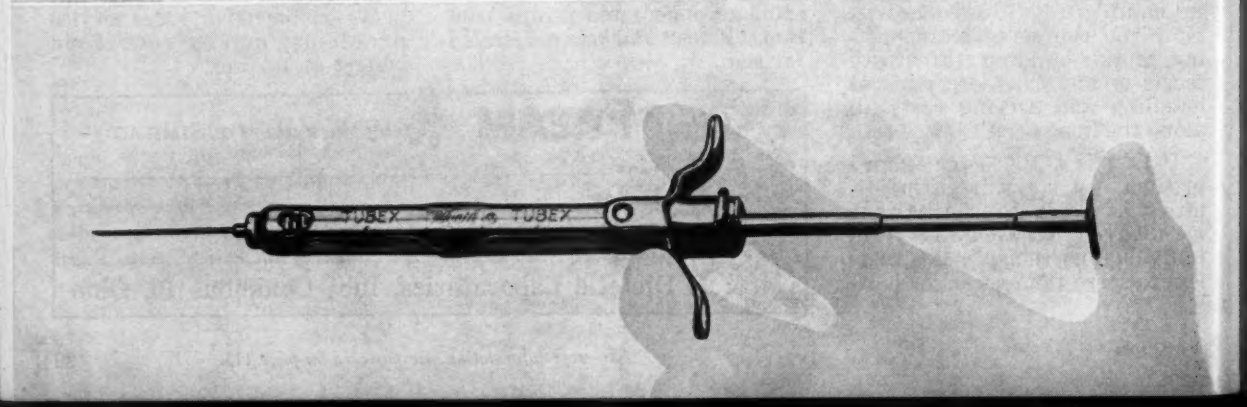

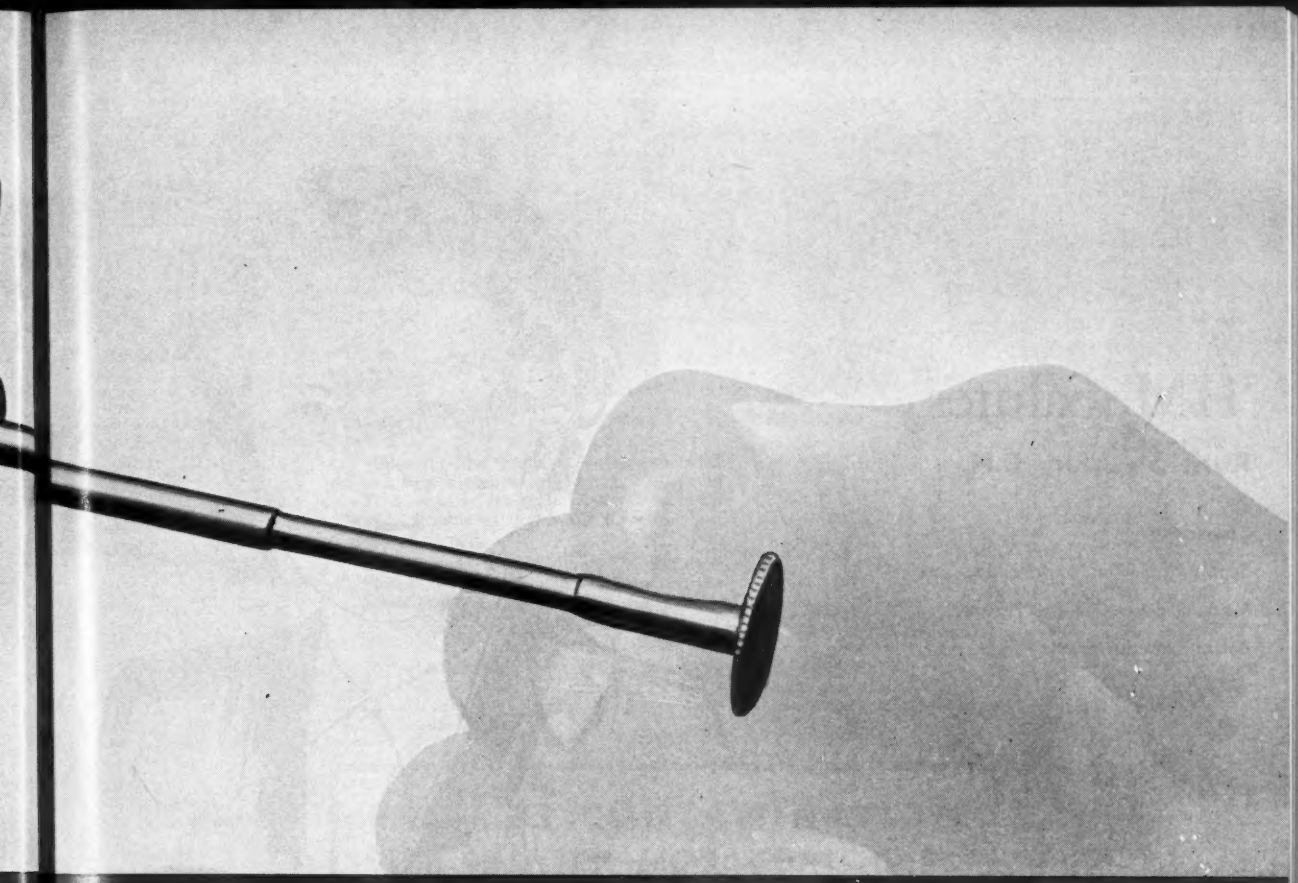

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1. Bogash, R.C., and Pisanelli, R.: Hosp. Management **80**:82 (Nov.-Dec.) 1955. 2. Hunter, J.A., et al.: Hosp. Management **81**:82 (March) 1956. 3. Hunter, J.A., et al.: Hosp. Management **81**:80 (April) 1956.

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Ruth Sleeper, R.N.

Director
School of Nursing and Nursing Service
Massachusetts General Hospital
Boston, Massachusetts

■ RUTH SLEEPER, R.N., B.S., M.A., L.H.B., B.SC., was the first president of the National League for Nursing, serving from June, 1952 to June, 1955 She is an acknowledged leader of the nursing profession both in the United States and abroad. She serves humanity as Director of the School of Nursing and Nursing Service of Massachusetts General Hospital in Boston, Massachusetts, a position that she has held for ten years.

Erudite scholar, gracious leader and congenial personality, Ruth Sleeper has been dedicated for years to the improvement of the care of the patient through improvement in nursing care and education of the nurse. She was one of the original organizers of the Joint Commission for the Improvement of the Care of the Patient and served as chairman of this august body from 1951 to 1953. Her gracious presentation of the position of nursing in deliberations with representatives of the hospital and medical fields allayed much of the bitterness that had been generated through the publication of the Brown report on the future of nursing. Her ability to negotiate and to compromise intelligently undoubtedly saved the program of accreditation of nursing schools conducted by the National League for Nursing when the existence of this important program was seriously threatened by minority representatives of the medical profession and of hospitals.

Ruth Sleeper was one of the pioneers in experimentation with education for nurses in reducing the amount of time spent by nurses in repetitive experiences.

An outstanding educator for a long time, Miss Sleeper served as president of the National League of Nursing Education from June, 1944 to June, 1948. She now holds membership on such important bodies as the Health Resources Advisory Committee to the Office of Defense Mobilization, the expert panel on nursing of the World Health Organization, and the Board of Directors of the National League for Nursing. In addition to this, she presently serves as Chairman of the Education Committee of the International Council of Nurses.

Ruth Sleeper's contribution to the quality of patient care in our hospitals is not measurable by tangible standards. Her contributions are immeasurable and Hospital Management is proud to recognize her with this salute. ■

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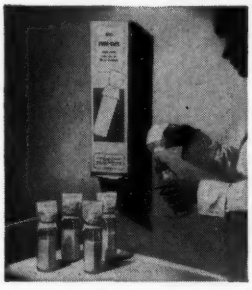

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BOOKS

Continued from page 26

Other developments such as Optical Brighteners and GMC are defined and discussed. Much is written about the uses of detergents in Industrial, Maintenance and Household cleaning describing abrasive compounds for heavy duty cleaning, lightly abrasive ones for household use and those containing no abrasive for the many other cleansing purposes. The writer also describes processes used by the texile industries for measuring properties of surface-active agents and their power to lower surface tension. The closing chapters are devoted to the choosing of the proper detergent for the specific job to be done, and the future of synthetic detergents. The fact is emphasized that the only reliable way of testing a detergent is by actual washing tests. The reader will be impressed with the wide scope and importance of the word — "Cleansing".

All in all, I find the book very interesting and educational. I believe it will be of value to those persons responsible for any of the cleaning processes common to the hospital field; and of prime importance to the Executive Housekeeper in her many and varied cleaning problems; to the Laundry Manager in the processing of the hospitals linens entrusted to his care; and to the Director of Dietetics in the cleaning of cooking equipment, utensils and dishes. *Ray J. Gabrielson, Presbyterian Hospital, Chicago, Ill.* ■

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MOBILIZATION AND HEALTH MANPOWER A Report of the Subcommittee on Paramedical Personnel in Rehabilitation and Care of the Chronically Ill. *Published by the Superintendent of Documents, Office of Defense Mobilization.*

■ A NATION-WIDE SHORTAGE of trained workers is preventing the benefits of modern rehabilitation from reaching vast numbers of the nation's disabled. This was one of the conclusions in a report released by the Health Resources Advisory Committee of the Office of Defense Mobilization. The report asserted that although the number of such personnel had increased substantially in recent years, the number today is still not sufficient to meet present national needs or expected future needs.

The report indicated that the need for physical therapists is approximately 12,500 and approximately 9,500 occupational therapists are also needed. To meet the nation's needs for medical and psychiatric social workers, would require graduation of 800 to 1,000 new medical social workers and 1,000 new psychiatric social workers each year.

No adequate estimate could be made of the national need for clinical and counselling psychologists, speech and hearing therapists, and rehabilitation counsellors, but the need now far outstrips the supply.

Despite these serious shortages of specialized rehabilitation personnel, the report said that through its current program the Federal Government had adequate mechanism to meet its responsibility for assisting in increasing the national supply of such personnel and added that no new federal legislation for this purpose was needed at this time.

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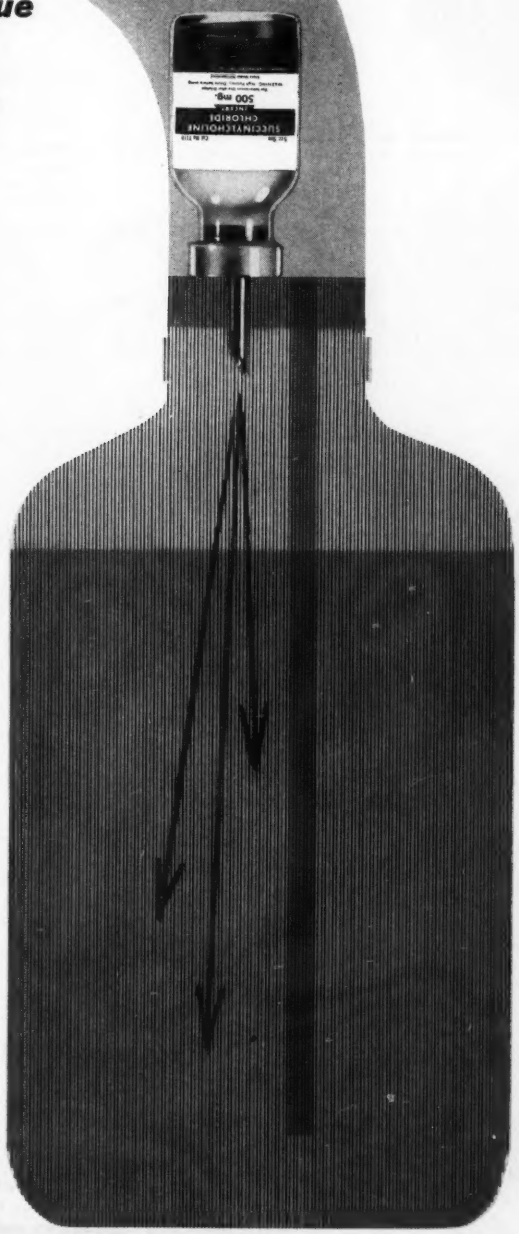

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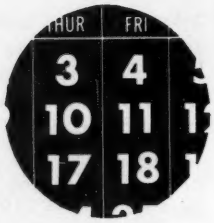
Hospital Calendar



July

15-20 . . Institute on Hospital Accounting, American Association of Hospital Accountants, Indiana University Bloomington, Indiana, William M. Pierce, Sr., Ex. sec., 530 E. 31st St., Chicago 16, Ill.

August

12-18 . . World Federation for Mental Health, Munich, Germany, Secretariat, 19 Manchester Street, London W. 1, England.

29-Sept. 2 . . International Congress of Blood Transfusion, Boston, Mass., Dr. J. Julliard, Sec. General, 57 Boulevard L'Auteuil, Boulonge-sur-Seine, France.

September

3- 5 . . American Association of Blood Banks, Somerset Hotel, Boston, Mass., Miss Marjorie Saunders, secretary, 725 Doctors Building, 3707 Gaston Ave., Dallas, Tex.

9-12 . . International College of Surgeons, Palmer House, Chicago.

10-14 . . American Congress of Physical Medicine and Rehabilitation, Ambassador Hotel, Atlantic City, N. J.

10-14 . . Second International Congress of Dietetics, Congress Palace of Esposizione Universale Roma, Rome, Italy, Compagnia Italiana Turismo, Wholesale Department, 193, Piazza Colonna, Roma, Italy.

15-17 . . American College of Hospital Administrators, Palmer House, Chicago, Ill.

17-20 . . American Association of Nurse Anesthetists, Palmer House, Chicago, Ill.

17-20 . . American Hospital Association, Palmer House, Chicago, Ill.

26-28 . . Michigan State Medical Society, Sheraton-Cadillac Hotel, Detroit, Michigan.

October

1- 5 . . Second International Congress on Medical Records, Shoreham Hotel, Washington, D.C., Doris Gleason, C.R.L., Executive director, 510 N. Dearborn, Chicago 10, Ill.

8- 9 . . Oregon Association of Hospitals, Salem, Ore., Ralph W. Nelson, exec. sec., P.O. Box 1271, Portland, Ore.

8-12 . . American College of Surgeons, 42nd Clinical Congress, San Francisco.

8-15 . . World Medical Association, Havana, Cuba.

9-12 . . American Dietetic Association, Schroeder Hotel, Milwaukee, Wis., Miss Ruth Yakel, sec., 620 N. Michigan, Chicago, Ill.

10-11 . . Washington State Hospital Association, Chinook Hotel, Yakima, Wash., John Bigelow, Executive secretary, 370 Skinner Building, Seattle, Wash.

17-19 . . Florida Chapter, American Association of Hospital Accountants, institute and workshop, Daytona Plaza Hotel, Daytona Beach, Fla., Helen Hamil, sec., Mercy Hospital, Inc., Miami, Fla.

18-19 . . Mississippi Hospital Association, Hotel Edwards, Jackson, Miss.

22-24 . . Ontario Hospital Association, Royal York Hotel, Toronto, Ontario, S.W. Martin, Associate executive secretary-treasurer, 135 St. Clair Ave. West, Toronto 7, Ont.

24-26 . . California Hospital Association, San Jose, Calif., Avery M. Millard, exec. dir., 523 Phelan Bldg., 760 Market St., San Francisco, Calif.

27-28 . . American College of Osteopathic Hospital Administrators, Sheraton-Cadillac Hotel, Detroit, Mich., R. P. Chapman, Executive secretary, 604 Kahl Bldg., Davenport, Iowa.

28-31 . . American Osteopathic Hospital Association, Sheraton-Cadillac Hotel, Detroit, Mich., R. P. Chapman, Executive secretary, 604 Kahl Bldg., Davenport, Iowa.

31-Nov. 2 . . Maryland-District of Columbia-Delaware Hospital Association, Shoreham Hotel, Washington, D.C., Albion K. Parris, exe. dir., 200 W. Baltimore St., Baltimore 1, Md.

List Your Meetings

As soon as the dates for the next succeeding meeting of an organization have been determined an official should forward those dates at once to Editor, Hospital Management, 105 W. Adams St., Chicago 3, Ill. to insure appearance here.

November

8- 9 . . Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City, Okla., Cleveland Rodgers, exec. dir., P.O. Box 1738, Tulsa, Okla.

12-16 . . American Association of Inhalation Therapists, Park-Sheraton Hotel, New York City.

12-16 . . American Public Health Association, Convention Hall, Atlantic City, N.J.

15-16 . . Kansas Hospital Association, Baker Hotel, Hutchinson, Kansas, Charles S. Billings, Executive Director, 1133 Topeka Ave., Topeka, Kansas.

15-17 . . Arizona Hospital Association, Phoenix, Ariz., Guy M. Hanner, Administrator, Good Samaritan Hospital, 1032 East McDowell Road, Phoenix, Ariz.

16-17 . . Virginia Hospital Association, Hotel Roanoke, Roanoke, Va., Raymond E. Hogan, secretary, Giles Memorial Hospital, Pearisburg, Va.

27-30 . . American Medical Association, Clinical Meeting, Seattle, Wash., Dr. George F. Lull, sec., 535 N. Dearborn, Chicago, Ill.

29-30 . . Florida Hospital Association, Jacksonville, Fla., Jack F. Monahan, Jr., Ex. sec., 1216 E. Colonial Dr., Orlando, Fla.

December

3- 7 . . American Medical Association Seattle, Wash.

1957

February

4- 5 . . Midyear Conference for Presidents and Secretaries of State Hospital Associations, Palmer House, Chicago.

27-Mar. 1 . . American Protestant Hospital Association, Palmer House, Chicago.

HOSPITAL Management July 1956

Dads' Day in Nurses' Training

by **Florence K. Lockerby**

Photographs by:
George Knisley

Cover photo courtesy
of the Chicago Tribune

■ SEVENTY-TWO FATHERS of freshman students at the St. Luke's Hospital School of Nursing in Chicago, spent a day at the school and hospital to find out what their daughters are learning and how a hospital is run.

"Fathers' Day", first held at St. Luke's last year, proved to be such an effective public relations', recruiting and educational medium that it has become an annual event.

The St. Luke's Hospital photographer shadowed Mr. William P. Kent of Park Forest, Illinois and his daughter, Mary, during the entire day's schedule of classes, luncheon, tours, tea, dormitory "open house" and an evening performance of a play.

Fathers of the freshmen came from California, Michigan, Wisconsin and Indiana as well as Illinois and the Chicago area to participate in "their" day. The ninety-four freshman students and faculty of the school organized the program to demonstrate what dads were getting for their "tuition" and "other expenses" money.

Miss Lockerby is instructor in communication at St. Luke's Hospital School of Nursing, Chicago, Ill.

Mary introduces her dad to Director of the School, Miss Edith D. Payne. Student hostesses and faculty were on hand to greet dads as they "checked in" and were "tagged" with name and home-town badges.

Before day's activities begin, Mary and her dad take time to read "A Shaft of Light" published by freshmen editors to "cover" the event.

Instructor in nursing arts, briefs Mr. Kent on admission procedures presented during one of classes fathers and daughters attended.

While Mary ate in the cafeteria with other students, Mr. Kent was a guest at a luncheon where fathers met faculty, other nurses, hospital administrators, representatives from Board of Trustees, Woman's Board and Medical Staff.

Small groups of fathers toured the hospital where they saw kitchens, the clinic, ward, semi-private, and private floors and the chapel. Faculty members conducted tours.

Mary's father observes his daughter at the Nurses' Station while an instructor checks her charting.

At tea-time, the freshman chorus, composed of 94 student nurses, sings for their fathers and guests.

The Kents, two other fathers and daughters and a third student (center) whose doctor-father was unable to come from Philippine Islands, start out on their dinner date. After dinner, fathers, daughters and invited guests attended "Stage Door" presented by freshman class. Members of House Staff played male roles.

The Variable Height Bed

A study in patient comfort and efficiency of care

by Harold E. Smalley, M.S.I.E.

■ WHEN ONE SETS OUT to discover areas of greatest need with regard to methods engineering, he is impressed with the importance of the hospital bed and its environment as an essential instrument for health care. When a patient is admitted, he is assigned a bed with which he will be intimately associated throughout his hospitalization. To the patient, the hospital bed is a medium for rest, comfort, and convenience; to the doctors, nurses, and other members of the health team, it is a vehicle of therapy and recuperation; to the non-professional personnel and to the several service departments, it is a piece of hospital equipment which requires a certain amount of maintenance and service; to the hospital administration, it is a capital investment subject to depreciation and obsolescence costs. To all these, the hospital bed has different significances but no objective analysis of the methods and procedures attending patient care can avoid the conclusion that the hospital bed plays an important role in providing the patient with those services needed for recovery. As additional evidence of the importance of the hospital bed, it is common practice to express hospital size in terms of number of beds.

In the interests of serving the greatest number, studies aimed toward the improvement of the hospital bed should begin with conventional types designed for the great majority of patients, commonly referred to as typical patients. After a degree of success has been achieved with the conventional bed, the methods engineer should turn to other types such as features for atypical patients, for the geriatric patient, for the young and vigorous patient, for varying age groups of pediatric patients including infants, and for the many kinds of patients hospitalized with unusual or rare illnesses and infirmities.

Approach to Problem Area

A logical approach to a hospital bed project would seem to be aimed toward an analysis of the existing bed with a view toward changes in hand and body motions, tools, workplace, equipment, process, product, and raw material. It is difficult to make a prognosis as to whether the optimum design of a hospital bed will result from a redesign of the existing bed or a completely new design unlike contemporary manufactured products, but the engineering approach to this problem should tend to answer this question. No engineering study will be complete without due consideration being given the interrelationships between the hospital bed and concomitant furnishings, equipment and facilities.

The patient's attitude toward his illness is likely to be highly correlated with the patient's opinion as to the calibre of treatment and care he is receiving from the hospital. The average patient is not likely to discern between professionals and non-professionals, between business office and pharmacy, or between maintenance and dietary departments as regards the degree of satisfaction or dissatisfaction he receives from hospitalization. In short, he probably forms his opinions, ra-

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Based upon a pilot study of the Hospital Bed Project conducted at Presbyterian-Woman's Hospitals under the auspices of the University of Pittsburgh School of Nursing by the author in collaboration with Anne Roebuck and Gearlean Swentzel and assisted by Charles Israel and Emanuel Sergakis.

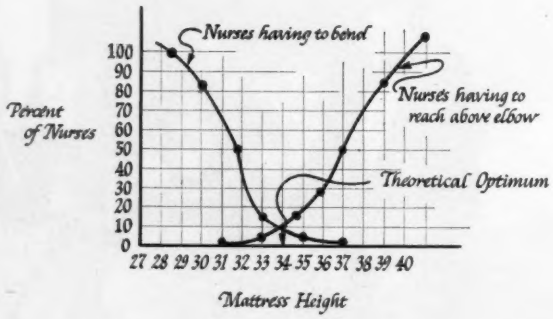

FIGURE 1

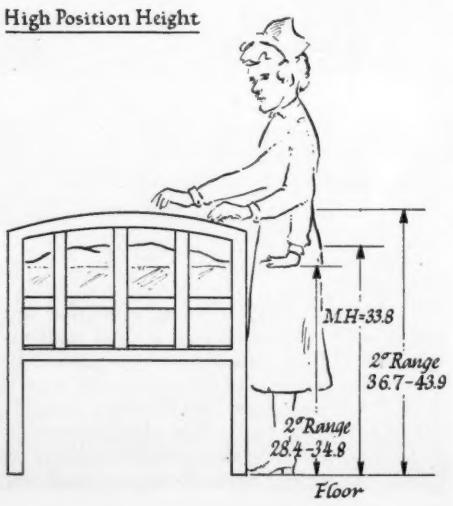

FIGURE 2

FIGURE 4

Work measurement data can be summarized as follows:

Bed	M	σ	σM	X/M	Avg. Perf.	Total N.T.	F&P Allow.	Total All. Time	Std. Time
Raising:									
Two-Crank	.742	.042	.014	3.7%	106%	.782	.094	.876	0.88
One-Crank	.157	.009	.005	6.5%	116%	.182	.022	.204	0.20
Powered	—	—	—	—	—	—	—	0.62	—
Lowering:									
Two-Crank	.740	.041	.014	3.6%	107%	.779	.093	.872	0.87
One-Crank	.153	.008	.005	6.3%	115%	.175	.021	.196	0.20
Powered	—	—	—	—	—	—	—	0.61	—
Raising plus lowering:									
Two-Crank								—	1.75
One-Crank								—	0.40
Powered								1.23	—

tional or irrational, in terms of the care he receives from "the hospital". Under such circumstances, the psychology of the patient, as it relates to the hospital bed, takes on an added measure of importance. The hospital bed is one of the patient's first contacts with hospital equipment and facilities. It is his steady companion for a major portion of his hospital tenure. The average well person spends perhaps seven to nine hours per day in bed, while the typical patient, prior to ambulation, spends 24 hours per day in bed, and after ambulation, certainly more than the classical eight hours.

Manufacturing and Distribution

It appears that manufacturers of hospital furniture are genuinely interested in improvement and that they are responsive to patient needs as such needs are reflected by hospital spokesmen. Unfortunately, those members of the health team most familiar with problem areas are busy administering care and do not have the time nor the technical training necessary to convey practical ideas to those in a position to give relief. There seems to be a need for technical liaison between hospital personnel and hospital equipment manufacturers in the interest of expediting selective, progressive innovation.

Experience has shown that, even if a theoretically superior product is designed, production and marketing intricacies often thwart potential savings. A relatively small demand for a new product cannot make possible the economies of manufacture and distribution inherent in standardization, specialization, and volume of manufacture. The feasibility of cooperative purchasing by groups of hospitals or by an association of hospitals to overcome this difficulty should be investigated. In addition, manufacturers and philanthropic organizations might be persuaded to jointly subsidize the manufacture of a promising item for a limited period of time until the merits of the item have motivated demand. In this connection, studies need to be made of the nature of distribution channels with regard to hospital supplies and equipment. It might be possible to reduce the deficit of manufacturing cost over competitive price by reducing the cost of distribution. Fruitful results from such a study would not necessarily solve all the problems involved, but it might enable many enterprising developers to put their manufactured products at the disposal of hospitals in the interests of increased economy.

Hospital Bed Project

The general objective of the hospital bed project is to determine criteria which will permit the establishment of hospital patient unit specifications as to materials, design features, and work methods. The hospital bed project is a long-range

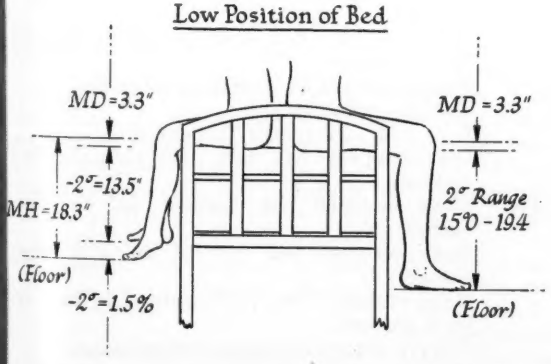

FIGURE 3

FIGURE 6

The gross savings in work content possible by use of the powered bed would be:

	Two-Crank	One-Crank
Standard time	1.75	0.40
Standard time of powered bed[1]	0	0
Gross saving	1.75	0.40
Average frequency	4	4
Gross saving per day	7.00 min.	1.60 min.
Nursing cost	$ .027/min.	$ .027/min.
Gross saving per day	$ .189	$ .043
Required saving	$ .35	$ .27
Powered bed feasible?	No	No

[1]Assuming switching time to be negligible and internal work is productive.

program of methods analyses and pure and applied research based upon the principles of management engineering and the methods of scientific inquiry. Among the areas requiring investigation are the hospital bed, variable-height features, bed making procedures, the bed unit, the patient unit, and special requirements.

Pilot Study

Before embarking upon the long-range hospital bed project, it appears desirable to conduct a pilot study for the purpose of gaining experience which will serve as a guide to future investigations. Another purpose of such a study is to discover and specify features of the variable-height hospital bed which will incorporate the easiest, quickest, least fatiguing and most economical methods of operating the bed, the safest and most comfortable bed for the patient, and the soundest financial investment for the hospital. In this pilot study, the principles and techniques of work simplification are modified as required to accomplish major objectives while attempting to maintain an optimum quality of patient care. Features are investigated which apply to typical patients, studies are restricted to the variable height beds, methodology is confined largely to the usual and ordinary analyses of motion and time study, and conclusions take the form of recommendations rather than scientific findings.

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FIGURE 5
Nursing Procedures and Saving of Time

Bed	Change	Std. Time	Critical Time Value	Examples of Procedures Justifying Change
Two-Crank	Raising only	0.88	8.8	Prepare patient for dissolving gallstones. Give pre-breakfast care. Give A.M. care (partial, patient up).
Two-Crank	Lowering only	0.87	8.7	Make occupied bed (with patient in bed, no linen change). Prepare patient for dissolving gallstones. Give pre-breakfast care. Give A.M. care (partial, patient up).
Two-Crank	Raising and lowering	1.75	17.50	Give complete bed bath (not including bed making).
One-Crank	Raising only	0.20	2.00	Assist patient to bathroom. Assist doctor with dissolving gallstones. Make occupied bed (patient up, no linen change). Make occupied bed (patient up, with linen change). Make occupied bed (with patient in bed, no linen change). Prepare patient for dissolving gallstones. Give pre-breakfast care. Give A.M. care (partial, patient up). Give complete bed bath (not including bed making).
One-Crank	Lowering only	0.20	2.00	Assist patient to bathroom. Assist doctor with dissolving gallstones. Make occupied bed (patient up, no linen change). Make occupied bed (patient up, with linen change). Make occupied bed (with patient in bed, no linen change). Prepare patient for dissolving gallstones. Give pre-breakfast care. Give A.M. care (partial, patient up). Give complete bed bath (not including bed making).
One-Crank	Raising and Lowering	0.40	4.00	Make occupied bed (patient up, no linen change). Make occupied bed (patient up, with linen change). Make occupied bed (with patient in bed, no linen change). Prepare patient for dissolving gallstones. Give pre-breakfast care. Give A.M. care (partial, patient up). Give complete bed bath (not including bed making).

A Training Program

For Nurses' Aides and Auxiliaries

by Margaret G. Arnstein

■ I AM HAPPY to have this opportunity to describe the nationwide nursing aide training project which the Public Health Service initiated at the suggestion of the National Health Resources Advisory Committee of the Office of Defense Mobilization. It was undertaken as an overall effort to improve the care of patients.

The person who knows how to do his job is more secure, better satisfied, and more efficient. In a hospital, an aide who knows how to do the job is also *safer*. I wonder about the gamble we take when we hire an untrained person who comes to a hospital and wants a job. Frequently she has little or no organized instruction. She is shown what to do by the nurses on the wards if and when they have time.

The person who knows how to do a job is also likely to be more satisfied with it. This is an important factor in preventing some of the turnover that occurs among hospital employees. In general, there is a great deal of turnover among the aides. Part of it is due, of course, to the great mobility of American families these days. People follow industry in their movements. Aides—and their husbands—say, "Florida is lovely in the winter," or "We would like to see California," and off they go. But their satisfaction with their present jobs can have *some* influence on whether they decide to move.

In the nursing aide training program, we are working with people who are already in their jobs. Since 1943 the number of aides in general hospitals has more than tripled. There were 34,000 then, and in 1954 there were 117,000. This is a tremendous increase. It was one reason why it seemed necessary to have a training program.

In some hospitals, the aides were well trained, but because of the great amount of turnover, training programs had to be started over again at short intervals. Some hospitals had programs ranging from one week to two months in length, with classes and supervised practice on the wards, but these were in the minority. Most hospitals had little organized training.

In 1952 four different groups—maybe others—had the idea, at about the same time, that there should be a training project. These groups were the National Committee for the Improvement of Nursing Service, the Health Resources Advisory Committee, the National League for Nursing, and the Public Health Service. The Health Resources Advisory Committee asked the Division of Nursing Resources of the Public Health Service to see what was needed.

We looked over the situation, collected information on the various teaching programs for aides, visited a number of them, and then from this background designed the program.

We wanted a handbook that could be used in any hospital, even if the staff members who would be teaching the aides had no previous preparation for teaching. Since we found that there was almost no common core of duties the aides were performing in all hospitals, we decided to prepare a looseleaf type of book so hospitals could take out material they would not need, and put in additional material they would need. We thought out the order of the material carefully, and wrote and arranged the lessons so that they can be shifted about according to hospitals' needs. The Division of Nursing Resources also wrote and issued the *Nursing Aide Instructor's Guide* for teachers in the project.

The American Hospital Association underwrote the printing and distribution of the *Handbook for Nursing Aides in Hospitals*, which came from the press early in 1954. The National League for Nursing arranged to conduct teacher training institutes across the country. State Leagues for Nursing organized committees representing nurses, hospitals, and vocational education, to guide the project in the states.

Since the Public Health Service is not connected with the actual teaching phases of the project, only in the early days of the program did we have any contacts with the state and local committees that were set up. I know there has been a good deal of interest and cooperation on the part of many people—industrial representatives, for example. The state departments of vocational education have been extremely helpful and in some places have employed the teacher trainers themselves. Every state now has a committee, and 37 states have training programs.

The basic plan is to send one to four teachers from a state to a regional institute. They come back and arrange local workshops where they teach the people who will instruct the aides. When possible, the hospitals select supervisors or head nurses to teach the aides, but often it has been necessary to use staff nurses or even practical nurses as the instructors.

Both the handbook and the instructor's guide are used in the institutes, the workshops, and the hospitals.

The latest count on the extent of the project was made in August. In about 18 months, 1,350 hospitals and nursing homes sent personnel to the institutes. These hospitals employ about 72,000 aides, or almost two-thirds of all aides working in hospitals. We don't actually know, of course, whether every one of these aides received the training—but at least there was someone available in the hospital who could teach them.

In the teaching method followed, the first step is to make a skill inventory to find out just what skills the aides already have and what skills they need to develop. Instruction may start with procedures the aides know the least about—or it may go straight through all the procedures they are expected to to know. The four-step method is used:

1. Put the "students" at ease, and explain the purpose of the lesson.

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Miss Arnstein is Chief of the Division of Nursing Resources, Public Health Service, Washington, D.C.

This talk was given before the American Osteopathic Hospital Association in Washington, D.C., November 2, 1955.

Problems of Moving Two Hospitals

by H. E. MacDermot, M.D.

■ IT IS NOT OFTEN that a long established hospital moves away from one site to another, and still less so that two such hospitals are brought together on the same site. The truly gigantic operation of this sort which embraced the combination of five New York hospitals into the one centre will be at once recalled, but this kind of moving is not common in the hospital world. Each instance is likely to have its own problems and ways of solving them.

Therefore it may be of interest to give some account of the transfer of the Montreal General Hospital and its Western Division to a single site during 1955. I say "during" because the moving went on throughout six months, although the actual operation of the new building began on one day and was completed in one week.

Dr. MacDermot is associated with the Montreal General Hospital, Montreal, Quebec.

The hospitals involved were the Montreal General Hospital, Central Division (450 beds) and its Western Private Pavilion (300 beds). These were the two oldest English speaking hospitals in the city, the first dating from 1822 and the other from 1879. Time and geographical limitations had caught up with them. In 1948 a new site was bought and building operations were begun. This site was about one and a half miles from the older hospital which was in the heart of the city, and about a half mile from the other.

It need hardly be said that the period during which building was going on also included continuous planning for the transfer of staff, and — a very important detail — the coordination of two separate staffs into one, which was something for which there were no guiding rules except those of cooperation and judgment.

The move involved three main phases: material (furniture, equipment, and supplies); staff; and patients. It was in that order that the move was carried out.

The old buildings were extremely active, fully equipped institutions, even though much of the equipment was outmoded and worn out. It would have been quite impossible in any case to have moved the entire contents of the hospitals whilst still carrying on their work. This meant that the new buildings had to be almost entirely furnished and

After literally six months of moving, we gladly placed a "moved" sign on the old quarters.

equipped with new paraphernalia, even though the old was in many cases quite serviceable — tables, chairs, cupboards, lockers, for example. Also, the style of the new buildings differed so sharply from the old that the incongruity between the old furnishings and the new interior would have been too great. Two other departments to be considered were the pharmacy and the central supplies. It would have been impracticable to pack and move the contents of these overnight or indeed in several weeks. Completely new stocks were bought and put in before the move took place.

Medical Records

One thing that could be moved beforehand, however, was the mass of past records. The patients' records had been kept on hand for a period of about 30 years, those previous to that being destroyed for lack of space, although admission cards were kept. These records were moved up into their allotted space six months ahead of time. It led to inconvenience because they had to be consulted frequently, but it was better to have as much done beforehand as possible. Their packing and transfer led to a small incident. They had all been packed by special packers in cartons. These made a most imposing pile when assembled for the trucks, and the newspapers, who were following the move closely, sent up a photographer for a

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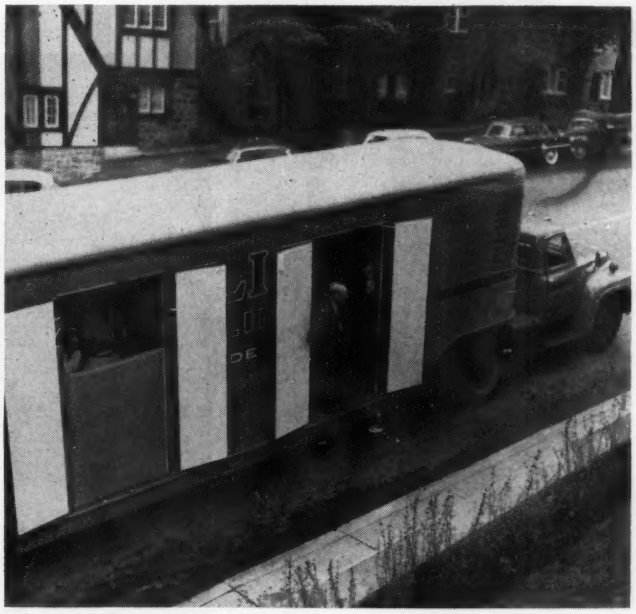
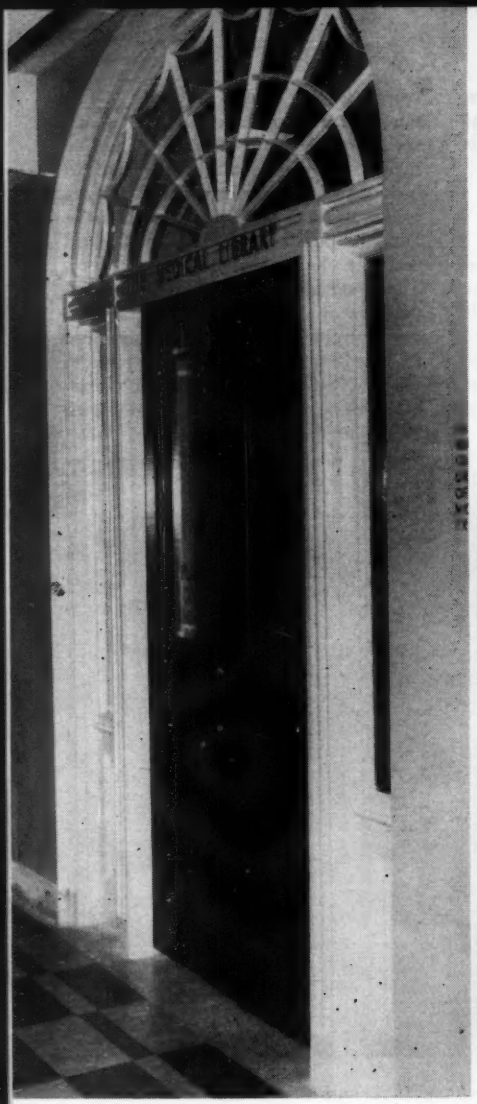


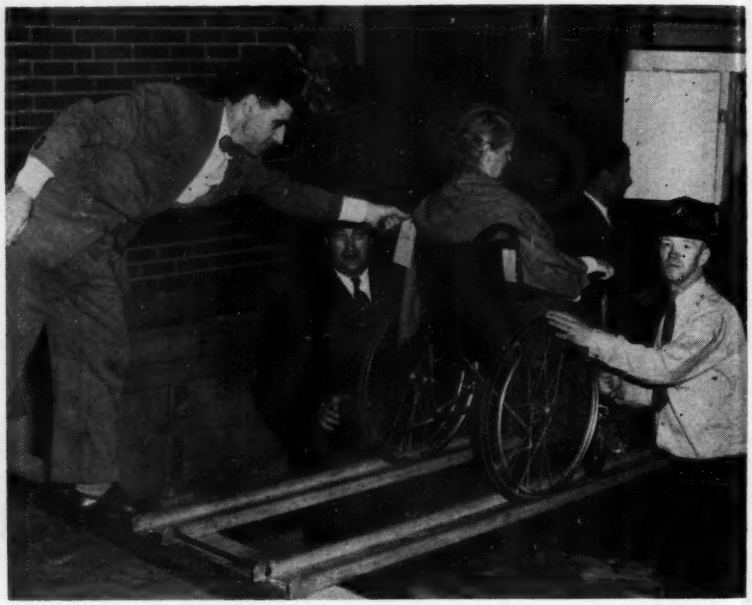
Patients were divided into stretcher and bed cases—those that had to be moved lying down. Special vans transported these patients to the new hospital.

The Montreal General Hospital, its Central Division and its Western Private Pavilion united into one new hospital.



One of the blessings of the "move" was a new medical library and the induction of the unit system for our medical records.

A special loading ramp was built to assist the wheel chair patients.



picture. When he saw them he took one look and turned away. "Can't do anything with that" he muttered. The cartons were the empties of a local brewery and bore its name in large letters!

It might be added that one of the many blessings of the move was that it brought about the introduction of the unit system for these records. This had not been possible in the old establishment for various reasons.

The hospital then moved into an already fully equipped building, but for anyone else who has to do this sort of thing let them remember that no place is fully equipped until it has been worked in for some time. The various offices and departments soon found this out. They left everything behind except necessities, but the new premises were bare of the small things which soon become necessities — tables for telephones, racks, odd chairs, shelves, and hooks to give a few examples. These have been acquired gradually, but there was some intervening discomfort.

Transfer of staff

The quarters for the interns and the nurses home were completed some months before the hospital was ready. The interns were then moved in, with a residual group of four or five for night duty. Buses took the others to and fro each day. The same thing was done for the nurses.

The transfer of the patients was, of course, the most complicated part of the move, and though it went smoothly it called for a long period of careful planning. It was arranged to move in the private hospital on May 22 and the public patients on May 29. These were both Sundays, and the moving was done in the morning. Prearranged routes were followed and police escorts helped to keep them clear of traffic jams, but on Sunday morning the chances of this were small.

The patients were divided into (1) stretcher cases, (2) bed patients who had to be moved lying in bed — special vans took these, as well as paraplegics in their chairs — (3) walking patients, who were sent up in buses and limousines. Manila tags were given to each patient, on which were inscribed the name, type of transportation, and the nursing unit or room allotted.

A master movement schedule was prepared, covering all patients, and a physician acted as "despatcher", and was responsible for seeing that all patients left. Each ward was notified by phone when to send patients down to the despatching yard.

It was not possible to have nurses accompany the patients, but mem-

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On the Subject of Convalescent Care

What can be done for the patient with a long-term illness?

by E. M. Bluestone, M.D.

■ THE INTELLIGENT CRITIC scratching the surface of organized medical care cannot help viewing with misgiving, if not with alarm, the loose, indiscriminate and archaic plan of organization in which the convalescent patient is expected to recover his health and morale.[1] We have been witnessing the semantic transformation of *"chronic illness"* into *"long-term illness"* and latterly into *"prolonged illness"*, as we find that a kinder and less condemnatory name will somehow help the powers that be to respond to this expanding need and plan for it understandingly.[2] The term *"convalescence"* remains the same and rightly so, because it is such an unusually accurate designation. We are dealing here with an easily identifiable phase of recovery from "acute" or "chronic" mental or physical illness. Whatever the response may be, the clinical requirements of such a patient are never in doubt as long as the etymology of convalescence, which is "growing strong", is borne in mind.

There are few left among us who would perpetuate the organization of independent hospitals for "chronic" patients in the manner that still survives in too many instances to shock our sensibilities.[3] To the relief of the social worker, who has thus far broken her heart over this problem, the general hospital is beginning to assert its rights over "chronic" as well as "acute", so long as the intensive need for a hospital bed can be proved.[4] It is, in fact, reaching out and taking under its protective wing, the bed in the patient's home in those instances where a bed in the hospital is not, or is no longer, required.

Dr. Bluestone is a consultant to Montefiore Hospital in New York City.

Address delivered before the New Castle County Medical Society, Wilmington, Delaware, at the Eugene du Pont Convalescent Memorial Hospital, November 15, 1955.

With the elimination of the criterion of duration-of-illness in the admitting office, as a basis for a decision when those who are otherwise eligible for in-patient service are turned away, we find ourselves moving logically to this next step in a communally-minded hospital policy. As the science of medicine progresses, duration of illness becomes a challenge to action rather than an excuse for inaction. We now know that subsidy in the home, if necessary, places at the disposal of the hospital a new and relatively inexpensive resource, highly acceptable to the patient, providing at the same time a treasure-trove of opportunity, medically and socially, as it complements the intra-mural work of the hospital.[5]

Need Total Program

We thus find that an integrated program of hospital care to cover all phases of illness up to the point of recovery exhibits an extra-mural as well as an intra-mural activity on a complete, comprehensive and, above all, continuous basis, responding to the needs of the near-sick (*preventive medicine*); the sick (*diagnostic and therapeutic medicine*); and the *recently sick* (*convalescent medicine*).

The formula on which it is based relates urgency (in the patient) to distance (from the hospital) in an inverse ratio and suggests the necessary subsidy for each phase of helplessness in accordance with need.[6] Where, for example, the family can afford the services of the practitioner no further question remains but, where they cannot, the hospital must make good whatever deficit he faces, medically and otherwise. It is far less expensive, and more profitable all around, to have such a partnership prevail than to deprive the physician of his opportunity by the transfer of the patient to an expensive hospital bed whether he needs it or not. The advantages of such an arrangement radiate far into time and space and belong to physician and social worker as well as to the sick man himself.

It should be easy to determine the place in medical-care planning where the convalescent patient belongs. We must, however, remember that current hospital policy being what it is, it would be a serious mistake to assume that all those who are discharged from the hospital are necessarily convalescent patients.

Program Planning

How shall we plan for the patient, still sick or hopefully convalescent, who does not need, or no longer needs, an in-hospital bed and has nowhere else to go during illness that does not compel the use of such a service? In the extreme case of the homeless one or, what amounts to the same predicament, the one whose home cannot be reestablished adequately by subsidy, we must find a substitute facility for his home, remembering that there can be no substitute for the hospital (except another hospital which is at least as good) for him who needs it. Here, then, are three possibilities for the care of any patient depending on the circumstances of his illness: (1) the hospital; (2) his own home; or (3) a substitute for his home, always with the understanding that the hospital of origin, which has a vital stake in the matter, will stand by and offer medical subsidy to the patient and his doctor, if necessary, on a continuing basis. This is a case of completing what has been started, on the ethical principle that the right to prescribe involves the obligation to follow up.

It stands to reason that the place of the practitioner, or family physician, in such an overall organizational pattern which takes in his traditional territory, is crucial. The

convalescent patient, regardless of the medical locale in which he was brought to his favorable status, is the practitioner's particular province. No special gift of prophecy is needed to foresee the physician's improved future where these simple and logical formulae — a modern design for medical living — are observed in practice as well as in principle. Under this arrangement the services of the hospital are, at long last, placed at his disposal not only for the care of his very sick patients inside of the hospital during periods of compelling diagnostic or therapeutic urgency, but also for those whom he can manage, with such help, in their homes. One has only to visualize a well distributed and tightly integrated extra-mural program like this for every hospital, solidly based on practitioner-cooperation in such a way that he will be given every facility available (staff plus equipment) to help him solve the problem in the patient's home wherever possible, to understand the possibilities of the new era in medical care.[7]

Program Cost

As to the cost of such an inclusive program, we know from convincing experimental evidence that it is considerably lower on a community-wide basis than must be borne under the current fragmented system in which the part dealt with independently is more expensive to maintain than the part dealt with in relation to the whole. As to the source of financial supply to meet this cost, the prevailing contributions with which medical economics must deal realistically remain, namely (1) the patient-source (with or without the support of voluntary health insurance or other third-party payments) self-help naturally being the best although it is not yet enough in the aggregate to cover maintenance costs; (2) the philanthropic-source (voluntary) to make good the difference; and (3) the government source (compulsory) at any level, to save the situation where the patient plus philanthropy do not meet the costs of maintenance and thereby precipitate the risk of government receivership. The superior value of patient-income cannot be denied and, certainly, philanthropic income has important elements of superiority over income from government. If any further conviction on this subject is needed, one has only to recall that such life-saving and life-prolonging experimental projects as Home Care came to us through voluntary, extra-budgetary, giving.

Up to this point the medical profession has exhibited a marked preference for the remunerative and easily digestible problems of the *"acute" patient* in the hospital or elsewhere. At the same time he who is diagnosed, or prognosed, as a *"chronic" patient* (including the *aged patient* whose years lengthen and complicate his medical history) is left to trail along, fed mostly on the crumbs and the leavings. The cumulative advances of medical practice supported by the new teachings of social practice, both of them increasingly productive, are however giving us a succession of cues after setting the stage for organized action and we have reached the point where no patient (and no physician in the service of his patient) need want for those facilities which will best suit his requirements. The *custodial case,* which is distinct from the so-called *chronic patient* because this is a social rather than a medical problem[8] is *sui generis* and therefore easily distinguishable for planning purposes. Where, then, does the *convalescent patient* belong in this plan of organization?

Care For Convalescents

As matters now stand, many convalescent patients are wanting in the kind of care which ought to be specially designed to meet the requirements of recovery. This suggests the need for a clear restatement of the definition, since any misunderstanding on this score may well be responsible for their wavering and unsatisfactory status. In actual practice we find them lodged and boarded in one of four places, assuming that they cannot meet the expense of adequate convalescent care under their own financial power: (1) in a hospital, outstaying its hospitality; (2) in their own homes, and too often on their own recognizance; (3) in the rare convalescent institution limited to, and specially organized for, patients with similar requirements in end-therapy, recuperation, and rehabilitation; or (4) in an institution where they are assigned indiscriminately among other miscellaneous classifications such as the chronic, the custodial, the aged, and, in some instances of greater carelessness and callousness, the mental.

The home being preferred to the hospital for continued care during convalescence, this is where most convalescent patients are to be found trying "to grow strong" again. Where there is an absence of continuous supervision and coordination by the hospital and the medical profession these are the locations where sequelae and relapses too frequently supervene, due either to a premature return to full activity or to the presence of unchanged and uncontrolled pathogenic circumstances. Our grievance in such a case rests on the separateness of the service which, in itself, breeds neglect. Lack of integration and continuity of care are largely responsible for weakening, or even nullifying, the original hospital effort. Our complaint loses none of its vigor from the fact that nature rather than the physician does most of the work during the stage of convalescence.

Premature Discharges

Where the home is inadequate, and interest in its readjustment is at a minimum, the patient is transferred as "cured", sometimes prematurely, to a secondary, independent, institution where he may or may not be interpreted correctly and assisted to recovery as a continuing therapeutic problem.[9] Institutions devoted solely to genuine convalescent care, scrupulously avoiding all other phases of active or continuing mental or physical illness, are only too scarce and these are not always subject to the jurisdiction of the hospital of origin. Other institutions, in which the convalescent patient finds himself exposed to a variety of nondescript diagnoses and prognoses, apart from their separateness, can no longer be accepted as useful except for their ability to keep the patient out of the cold. That nature often overcomes such handicaps is very much to her credit rather than to the credit of these institutions. One must never forget that the prognosis during convalescence is always good and the patient must therefore be accommodated accordingly. Where the prognosis is anything but good we are dealing with prolonged illness and not with convalescence.

The reasons for poor convalescent planning I venture to suggest, are (1) an excessive amount of preoccupation with the acute general hospital, resulting in an unwitting isolationism based on the obsolete theory that such an institution must only concern itself with the relief of medical urgency and limit its services to curable diagnoses of short duration; (2) a lack of definition,

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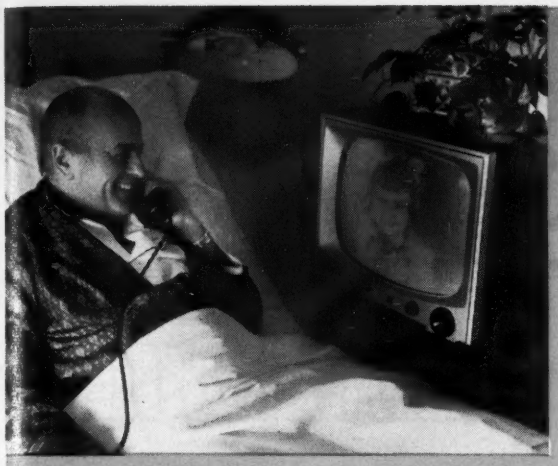

A hospitalized father is cheered . . .

Children Visit Patients By Television

by Lydia Bickford

■ THE VISIT VISION installation at Morristown Memorial Hospital, which makes it possible for patients to see and talk to their under-age children via TV and telephone, is a hook-up that can be arranged in hospitals which already have a closed circuit TV antenna system.

Memorial had recently installed its master antenna, to make possible better TV reception, when a member of the ITV company suddenly conceived the idea of the child visits through TV — and offered to try out the plan at our hospital.

Ideally, the ITV company supplies the hospital with a booth complete with the necessary equipment, which costs $2,500. In our case, we did not have enough room for such a booth, but our maintenance department was fortunate in finding satisfactory space in an unused telephone booth, installed a glass partition, and set up the necessary technical equipment behind it. This equipment includes a camera to photograph the child, a monitor TV set so he can see himself as he will be seen in the patient's room — and incidentally, keep within the bounds of the TV screen—the master antenna, a telephone, and lighting that is synchronized with the coin meter, so that the lights will come on when the quarter is deposited in the meter.

In purchasing the ITV booth the equipment listed above is all-inclusive, and the booth needs merely to be plugged in the nearest outlet. Even if a hospital wishes to purchase the proper equipment and have its own engineer install it, the cost would be easily as great, and perhaps greater, than the booth purchase. We did *not* purchase the equipment, but arranged to have the ITV Company cover the entire cost and defray this cost from the collections in the coin meter. After the cost has been covered in this way, the hospital will receive one-third of the proceeds and the ITV Company the balance.

The telecasts are technically like any closed circuit system, and for the layman, is best described as an arrangement as simple as a telephone extension in a home. Here at Memorial we use Channel Six for our Visit Vision chats, since we have no commercial station on that channel that is readily picked up. Visitors have sometimes asked if all patients who are tuned in on Channel Six can see the family using the Visit Vision—and the answer is yes. In fact, many patients who do not have children to visit them have been vastly amused by the antics of someone else's children as viewed in TV!

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. . . by a visit from his daughter.

Mrs. Bickford is Public Relations Director at the Morristown Memorial Hospital in Morristown, N. J.

ITV Company is the eastern division of Dage Television, Michigan City, Indiana.

Chief of Staff

by Charles U. Letourneau, M.D.

Part I

■ EVERY HOSPITAL ADMINISTRATOR should have a physician to whom he can turn for advice from time to time. This is so even if the administrator is himself a physician. No man is sufficient unto himself and every man needs an advisor.

Because his job is to concentrate upon the details of administration, the administrator may tend to focus on the administrative facets of the hospital. He needs to be reminded frequently of the purposes for which the hospital exists—to provide the highest quality of patient care that the community can afford.

Such a medical advisor exists in every hospital. In some hospitals he exists unofficially. This is bad. It breeds an atmosphere of secrecy, suspicion and jealousy even when there is no cause for mistrust.

The better practice is to recognize officially the medical advisor to the administrator and to assign to him certain duties and responsibilities. He may also be the executor of policy concerning the practice of medicine in the hospital. In most hospitals, this physician has come to be known as the *chief of staff*. His position is at once delicate and important. He is the keystone of good hospital-physician relationships. He must walk the tightrope of strict impartiality because his function is administrative rather than medical. His duties and responsibilities are poorly understood in most hospitals and this has led to confusion in relationships.

The name *"Chief of Staff"* is applicable to the senior administrative physician in any hospital. Whether he be a full time employee, a part time employee or a physician on the medical staff who has volunteered for the job, his functions are the same, regardless of title.

His chief function is to act as the administrator's right hand in professional matters but his status varies from hospital to hospital. He may be doing much more than this. Indeed, in some hospitals, he is the unofficial administrator because of the tremendous influence that he has acquired over the administrator and board of trustees of the hospital.

He is chiefly concerned with matters of professional service, professional accounting and the profession solvency of the hospital.

In the larger hospitals, he may be called the medical superintendent, the medical director, the director of professional services or the assistant administrator-medical. He is usually a full-time paid employee and he is the medical assistant to the administrator in most cases.

However, the larger institutions are in the minority. It is in the smaller hospital that the *chief of staff* truly comes in his own. In hospitals that are smaller than 300 beds, it is uneconomical to hire a full time medical-administrative official in addition to the administrator. To carry out the functions of the medical director therefore, a member of the medical staff is appointed to serve as *chief of staff* to assist the hospital administrator.

Make Function Clear

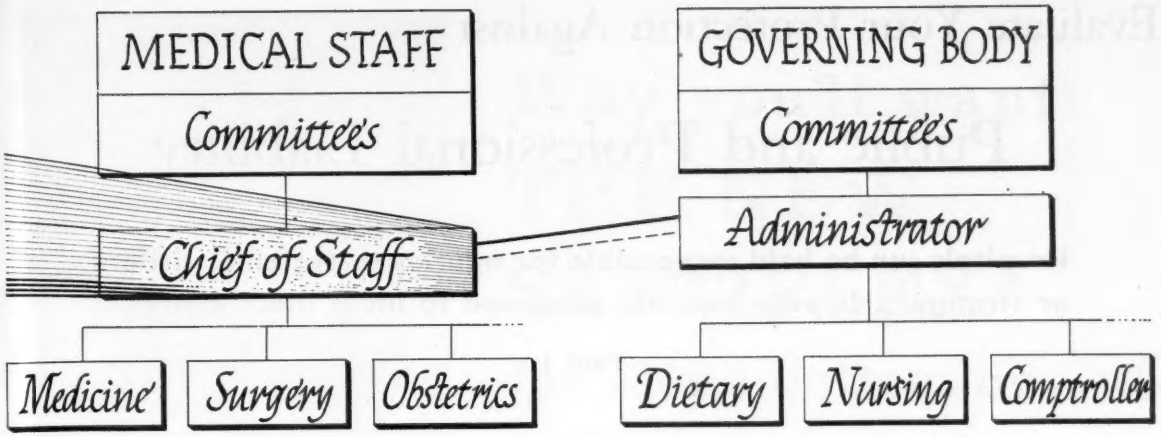
The exact function of the *chief of staff* should always be made clear by the governing body of the hospital. The *chief of staff* is a medical administrative officer with power and authority delegated from the administration of the hospital and answerable to this body. In other words, he is a member of the administrative team with primary loyalty to the administration rather than to the vested interests of his profession.

How poorly this principle has been understood can be illustrated by various examples taken from our own experience. In every instance, misconception of the duties of the *chief of staff* resulted in deterioration of hospital-physician harmony, loss of accreditation or administrative chaos.

In one hospital, the *chief of staff* was a purely honorary title. It was granted to the oldest physician on the staff as a reward for long and faithful service in the hospital. There were few, if any, duties attached to his job and the administrator was obliged to seek advice from unofficial sources. This created jealousy, and resulted in actual complaints of persecution by some of the physicians practicing in the hospital.

In another hospital, the *chief of staff* was also the president of the medical staff. He found himself in the awkward position of representing the administration and the physicians on the medical staff at the same time. In almost every instance, he was forced to take sides either for or against the administration. This resulted in unpleasantness, charges and counter-charges that eventually made fine reading in the local newspapers.

In this instance, the administration attempted to solve the problem by retaining the right of approval of the president of the medical staff.



This aroused the charge of favoritism so that only those doctors known to be sympathetic to the administration could become elected to the presidency of the medical staff. The answer in the latter case was to separate the duties of the *chief of staff* from those of the president of the medical staff.

In another instance, the *chief of staff* over-estimated the extent of his authority and exercised tyrannical powers over the doctors who practiced in the hospital. He was under the honest misapprehension that his position gave him authority to interfere in the practice of medicine of his colleagues. He eventually forced the resignation of two physicians from the medical staff because he disagreed with their methods and despised their ability. The remedy was to reduce his duties to writing.

Method of Appointment

We have found that the most satisfactory arrangement for the appointment of the *chief of staff* is to ask the medical staff to recommend candidates for the position.

In the well-organized hospital, it is customary for the physicians of the hospital, organized into the medical staff, to recommend a certain individual for consideration by the governing body for appointment as *chief of staff*.

The *chief of staff* should be selected for his administrative qualities rather than for his professional abilities. He will be called upon to perform some unpleasant tasks in disciplining his colleagues. An ability to carry out these duties without unpleasantness is an asset that should be duly considered.

Moreover, when he is recognized as a representative of the administration, the burden of his administrative responsibilities will earn for him the sympathy and respect of the medical staff and, in most instances, the cooperation of everyone.

If the functions of the *chief of staff* have been properly explained to the physicians they will make an honest attempt to recommend one among their numbers as the best possible to do the job.

The main attribute of a *chief of staff* is administrative and organizational ability. Because he wields the scepter of authority, he should have earned the respect of his professional colleagues and a knack for managing them. Respect is much more to be desired than popularity.

Because the *chief of staff* must work closely with the administration, and because he must carry out the policies established by the administration, he should be a physician who is acceptable to the governing body in the hospital and to the hospital administrator. Hence, the nomination of two or three candidates for selection by the trustees of the hospital will avoid a loss of face by a candidate who is unacceptable to the administration.

Status of Chief of Staff

The *chief of staff* is an administrative official appointed by the governing body of the hospital. He derives his authority from the governing body.

His status is a matter of delicacy. Whether it is better for him to function as an advisor to the administrator on a status of equality or as an assistant administrator responsible for the administrator is a question of circumstances. The personality of the administrator and the *chief of staff* will play a considerable part in the relationship between the two. It is a matter for the governing body to decide.

Whatever the decision, however, neither the *chief of staff* nor the Hospital Administrator must be left in doubt as to his relative rights and duties as regards the other.

Whatever be the status of the *chief of staff*, his authority and responsibility must not derogate from or conflict with the authority of the hospital administrator or a two-headed administrative monstrosity may result. Hospitals which can operate successfully under a medical head and a business head with divided responsibility are extremely rare. There is so much over-lapping of function that it would require a Solomon on the premises at all times to decide what was medical and what was administrative. For, in the last analysis, there is nothing that goes on in or around the hospital that does not, in some way or other, affect the welfare of the patients. Since patients are a concern of the physicians, these latter might well be excused for thinking that the *chief of staff* runs the hospital if his position has not been made clear.

What are the duties of the *chief of staff*? These are variable from hospital to hospital, but there are certain fundamental duties that he must carry out in addition to duties that may be assigned to him upon the recommendations of the medical staff.

Next month Doctor Letourneau will discuss the chief of staff, as advisor and his relationship to the medical staff.

Evaluate Your Protection Against

Public and Professional Liability

Hospitals can be held responsible for injuries to patients, visitors or strangers. Is your hospital prepared to meet these charges?

Part I

by Ralph H. Hester

■ THE HOSPITAL IS and should always be a community enterprise, whether public or private, profit or non-profit; it needs the support and faith of the community and the members of the legal profession in particular. The absence of any specific regulation and control in the statutes indicates not the absence of power, but rather a satisfaction on the part of the legislatures that hospitals are being carefully and properly managed, and that there is no need for state regulation. The hospitals themselves, by organizing into associations, and by grading according to set standards, have regulated themselves and raised the standard of quality and service far more than any legislative act could possibly do. They developed from the same roots as our churches and our schools. They are the fulfillment of a primary need of man. We cannot do without them and still consider ourselves a democracy.

So long as the trend of the courts' decisions is to discontinue granting immunity and hold hospitals fully responsible, it would seem advisable and good judgment to safeguard the hospital funds against awards for damages and the cost of lawsuits and to protect the employees and the public by carrying full insurance against every liability hazard.

Liability to the Public

In addition to Workman Compensation protecting the employees, a serious need exists for protecting the public, which includes the patient, visitor, or stranger within the hospital. Some forms that could be applicable are Public Liability, often referred to as Owners', Landlords' and Tenants' Liability. This includes five classifications as follows:

1. Premises and Operations,
2. Elevators,
3. Structural Alterations,
4. Product,
5. Contractural.

There should also be an exposure insofar as owned, non-owned, and hired cars are concerned. There may also be Druggist Liability if the hospital should own and operate a drugstore in connection with the hospital, which covers not only operations but errors and omissions. To be certain that a hospital is properly protected, it should counsel with its insurance agent. He will aid in fitting policies afforded by insurance carriers to the individual circumstances or exposures.

The ideal form is a comprehensive Hospital Liability Policy which covers all of these possible exposures. Some hospitals own automotive equipment and each car should be insured. Some have an exposure where employees use their own cars on hospital business, and in this case there is a need for non-ownership coverage. Then there is the case where hospitals own other property not used for hospital purposes, where there might be an occurrence which would be the basis for a claim. Great care must be exercised in selecting the insurance so that it does not exclude the very protection needed most.

Public Liability (Owners, Landlords and Tenants) can be purchased on a comprehensive basis with professional liability and many of the other forms of liability added as an endorsement. In some forms of public liability insurance, a set of minimum specifications is established by the engineering department of the insurance company. It would be well to learn those underwriting requirements when insurance coverage is considered.

Hospital Professional Liability Insurance

Hospitals have been interested in professional liability insurance usually where courts have found them responsible for tortious conduct. The result has been a limited and selective market, and a poor loss picture. Experience filed for hospital professional liability insurance with the National Bureau of Casualty Underwriters shows loss ratios of better than 100%. Up to the present time there has been no marked improvement.

The need for a well integrated professional liability insurance program for hospitals at an adequate rate level has been highlighted by the variety of policies and rates which have been in existence and by recent court decisions in many states holding charitable hospitals responsible for injuries to third persons whether strangers or paying or non-paying patients. The trend has been away from the immunity doctrine which has absolved charitable institutions from liability for torts in the past.

Motivated by these factors, the National Bureau of Casualty Underwriters undertook to develop a professional liability insurance program for hospitals which would give hospitals needed protection for professional liability claims and permit companies to write it at a proper rate level. Included in the program are appropriate policy and endorsement forms which incorporates details of coverage, underwriting rules, classifications and rates. Technically, it is thus possible to secure a professional liability and "malpractice" policy entirely separate from the public liability.

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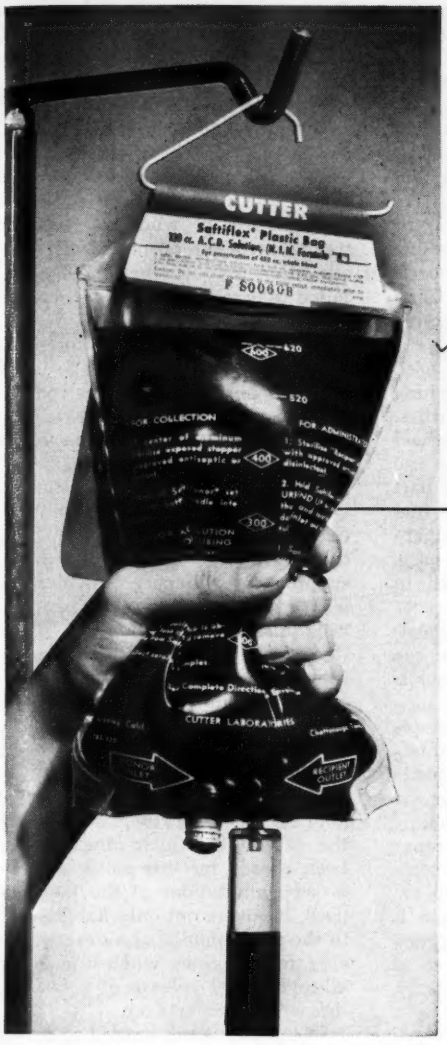
Mr. Hester is associated with the Hester Insurance Agency, Jackson, Mississippi. This paper was presented at the Mississippi Hospital Association Institute on Law and Insurance.



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For more information, use postcard on page 113.

Many companies will not write the professional liability or "malpractice" coverage unless they also write the "Owner, Landlord and Tenant" portion of the protection. There is sometimes a question about the classification in which a loss might occur. It is wise to insure both types of risk with the same company.

The term "hospital" is used broadly. It applies also to clinics, dispensaries or infirmaries, convalescent or nursing homes, homes for the aged, mental-psychopathic institutions, sanitariums and health institutions. It does not apply to osteopathic hospitals, institutions or clinics. Nor does it apply to the exposures embraced by Owners', Landlords' and Tenants' and Elevator Liability Insurance. The latter types of insurance continue to be necessary to cover exposures which are not related to professional error or mistake in giving treatment and which are associated with the usual premises hazards.

Insuring Agreements

The insurance is defined and circumscribed by the principal statement of coverage. The insurance company agrees, first of all, to pay the legal expenses for the insured hospital whether the claim be just or unjust. Regardless of the merits of the case, from the moment a claim is made, the insurance company steps into the place of the insured. It agrees to pay on behalf of the insured such sums for which the insured shall become legally obligated to pay as damages for cause of injuries, including death, sustained by any person arising out of malpractice, error or mistake committed during the policy period:

(a) In rendering or failing to render to such person, or to the person inflicting the injury, medical, surgical, dental or nursing treatment, including the furnishing of food or beverages in connection therewith, or

(b) In furnishing or dispensing drugs or medical, dental or surgical supplies or appliances if the injury occurs after the named insured has relinquished possession thereof to others, or

(c) In handling or performing autopsies on deceased human bodies.

Definitions

The essence of the coverage is determined at this point—it is the heart of the insurance contract and requires careful analysis.

The word *"injury"* is broad enough to include bodily injury, property damage or any other personal injury. The injury *must* arise out of malpractice in the rendering of treatment.

The words *"malpractice, error or mistake"* are not distinguishable one from the other. Their appearance is dictated by common usage. Generally speaking, they are synonymous in meaning.

The word *"treatment"* is not used in the ordinary sense as pertaining only to the application of remedies. It comprehends the use of wheel chairs, stretchers and beds. The use of these articles is considered a part of the treatment, within factual limitations. It also relates to supervisory acts and administrative care.

"Treatment" also is intended to encompass matters related to preliminary examination and diagnosis and to the accuracy of hospital reports. For example, the coverage is designed to apply to actions for malicious prosecution based upon hospital reports which lead to confinement of the patient in another institution. Coverage is intended for the consequences of erroneous writing of case histories or the improper disclosure of information in the belief the hospital is privileged to release the information. Coverage is even afforded for replevin of property, e.g., improper disposition of an amputated member of the body, for undue familiarity, assault by a hospital employee, personal restraint, and slander and libel if predicated on false reports. "Treatment" also includes blood donations on the theory that the services rendered before, during and after the donations constitute treatment.

Because there is no sound reason for distinguishing between injuries to patients whether caused by the general hospital fare or by a special diet, all food claims by patients are covered.

Explosions Not Covered

In defining the coverage as applying to damages because of injury to the person treated, *coverage is thereby intentionally avoided for injuries to others which may arise from anesthesia, oxygen fire, or explosion in the course of treatment of a particular patient.* However, injuries to others inflicted by a victim of alleged malpractice are covered. This is accomplished by the language "or to the person inflicting the injury". For example, if a patient is prematurely released from the hospital, becomes unconscious behind the wheel of his car and causes injury to a member of the public, the policy covers the liability that the hospital may have for the accident. It also covers injuries sustained by a member of the public caused by a deranged person who is receiving treatment in the hospital, where the allegation may be that the hospital failed to exercise proper supervision over the patient.

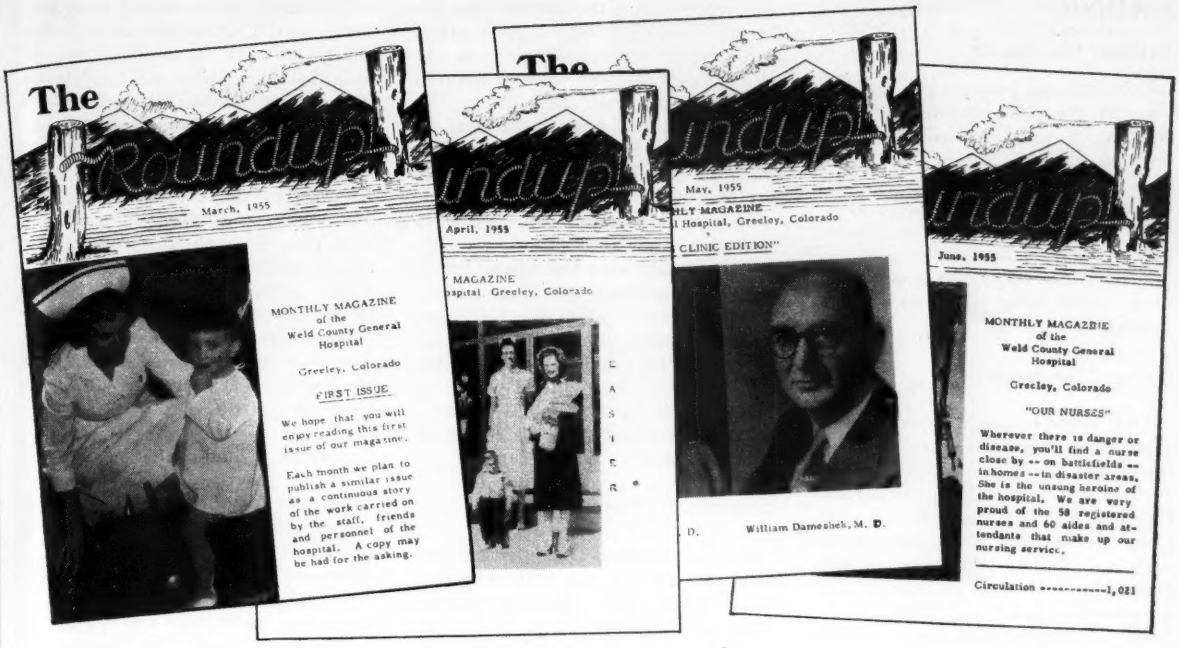
In paragraph (b) in the foregoing insuring agreement, coverage is afforded for both off-premises and on-premises accidents. This extension of coverage makes it unnecessary for hospitals to purchase fringe product liability coverage separately. Injury to anyone is covered when due to malpractice in furnishing drugs, medical, dental or surgical supplies or appliances, provided the injury occurs after the hospital has relinquished possession of these items to others. Under this language, injuries to patients as well as to other persons are covered when arising, for example, from faulty crutches, mislabeled medicines and the like.

Paragraph (c) which relates to autopsies is a further example of the care with which language has been chosen for this policy and the broad connotations of the language used. It covers not only liability due to the performance of autopsies, but also, for example, when due to the alleged illegal release of a body to the wrong undertaker.

The policy is not limited to coverage for injuries which occur during the policy period as is usual with other liability policies. To the contrary, *the policy covers injuries which occur at any time and at any place provided the malpractice, error or mistake was committed during the policy period.* This extension of coverage is necessary because of the late development of losses. Considerable time may elapse between the malpractice act complained of and manifestation of the injury. The manifestation, of course, may occur at any place.

Provision is contained in the policy for settlement of any claim or suit by the company only if written consent of the insured is given. This provision is traditional with professional liability insurance for hospitals.

This is the first part of a two-part article. Part II will appear in the August issue.


The Roundup
March, 1955
MONTHLY MAGAZINE
of the
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Greeley, Colorado
FIRST ISSUE
We hope that you will enjoy reading this first issue of our magazine.
Each month we plan to publish a similar issue as a continuous story of the work carried on by the staff, friends and personnel of the hospital. A copy may be had for the asking.
April, 1955
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Wherever there is danger or disease, you'll find a nurse close by -- on battlefields -- in homes -- in disaster areas. She is the unsung heroine of the hospital. We are very proud of the 50 registered nurses and 60 aides and attendants that make up our nursing service.
Circulation ----------1,021

the Roundup . . . by George Stout

■ YESTERDAY WE mailed out the sixth issue of our monthly magazine, "The Round-up". It has been so well received by the staff, personnel and townspeople that I thought perhaps you might like to hear about it. First off, you should know that we do the whole thing ourselves, even to the printing, at a unit cost of about 3½ cents, including mailing.

Circulation 1360

The circulation has reached 1360 — not very large when we think in terms of the daily papers or national magazine, but to the employees, patients and friends of the hospital it tells our story. A continuous story of the happenings and accomplishments — about the people who make up the "hospital family" — and about the kindly acts which bring comfort to the patients. Each issue features a specific department or facility. We also use this medium to further personnel and public relations.

In carefully written editorials and articles we discuss personnel policies, credit policy, visiting hours, parking, and the like. We use a few simple statistical tabulations showing the census, admissions, new babies, and comparisons of cost and standards with other hospitals. Photographs are used rather liberally. In the column "Hospital Faces" we give thumbnail sketches of employees, auxiliary workers and others. Our newest feature tells where our patients come from, i.e., neighboring towns, cities downstate, other states and foreign countries. Lately we have devoted a page to a photograph and a paragraph or two about the towns and cities in the 4,000 square mile area which the hospital serves. We also cover special events, auxiliary projects, articles on civil defense, safety, fire prevention, and "newsy" items in general.

The magazine is produced on an electric typewriter and a 1250 mul-plates and 20 pound mountie offset white paper. Photographs are made with a 4x5 speedgraph camera, a process camera to make half-tone negatives, and enlarger, and prescreened film. A bulk mailing postal permit and an addressograph machine greatly speeds up the processing.

Our mailing list includes service organizations like Rotary, Kiwanis, Lions, Chamber of Commerce, etc., city and county offices, employees, staff and Board members, mayors, superintendent of schools and ministers of Greeley and neighboring towns. All patients in the house on the day of issue receive a copy and copies are mailed to hospital administrators and other interested persons upon request. Judging from a recent survey we probably reach about 5,000 readers. From a public relations standpoint, we find the project very much worthwhile.

We will be happy to give detailed instructions to anyone interested in starting a similar publication. ■

Mr. Stout is assistant administrator of Weld County General Hospital in Greeley, Colorado.

Continued from page 50

for the express purpose of organization, of the term *convalescence* in relation to health as well as to the various clinical phases of illness; (3) inertia and negativism, which are operable in most areas that lie outside of the realm of acute illness; and (4) lack of knowledge concerning the new possibilities set forth here, among other wholesome trends in medical care.

Define Convalescence

The *convalescent* patient must, therefore, be defined in positive terms. He is the man who is safely recovering from acute or chronic illness and is on the way to complete restoration of health, or to such a degree of restoration as will leave him only with an unavoidable symptomless handicap. He no longer needs a hospital bed, but still belongs under hospital-medical supervision to help clinch his cure and prevent the consequences of neglect when the original etiological factors, environmental or personal, are suffered to remain active. Few men can fight their own battles alone; they need friends to help them.

The convalescent patient is, in fact, in much the same position as the worn-out individual, after long and arduous work, who needs a physical and perhaps mental opportunity to *recuperate* his strength and replenish his reserve, in this way preventing one or the other kind of illness from gaining a foothold in his body. The difference between the two is only one of degree. In both cases (recuperation to prevent illness, and convalescence from illness) the threat must not be permitted to materialize. We must prevent the unknown from occurring in the one case and the known from recurring in the other.

In view of the modern institutional practices with regard to convalescent care, it is of considerable importance to state the negative side of the definition as well. Convalescent care must not be equated with acute care, chronic care or custodial care in a melting-pot psychology which profits none of these groups. The "acute" or "chronic" patient is still sick, has a variable prognosis, and is not yet convalescent. The former is at the peak of his illness and the latter on the plateau, whereas the convalescent patient occupies a position on the slope far down from either and sure of a progressive approach to the normal line. He is also identified with a good prognosis which is, indeed, part of the definition, as I have already pointed out. The custodial patient on the other hand has passed through all three phases, acute chronic and convalescent, and is normal insofar as anyone with an irreversible scar, giving no symptoms and limited to this sign, can be. What the convalescent patient may need therefore is help in continuing progressively with his gains under the best possible auspices, uninfluenced by the close proximity in the same building of other phases of illness which, by their presence, confuse the organizational picture to his disadvantage — and theirs!

Organization Pattern

If this statement of the facts in the case is correct, we can devise a more satisfactory plan of medical care for the convalescent patient by following a more logical pattern of organization. If his home is adequate, or can be made adequate by subsidy, that may be the best place for him as he descends the slope on the graph from illness to recovery, provided, however, that hospital-medical supervision is continued in order to guarantee assistance in the effort. We must not ask the hospital to retain the convalescent as an in-hospital patient beyond the period of his needs, and this not only for the sake of the hospital which might require his bed for a more eligible patient but also for the sake of the patient himself. He should, of course, be given the benefit of every doubt. Each needless day spent in the hospital delays the time when he can breathe more freely in the knowledge of his release from institutional routine and his ability to be among his own, safely, once more.

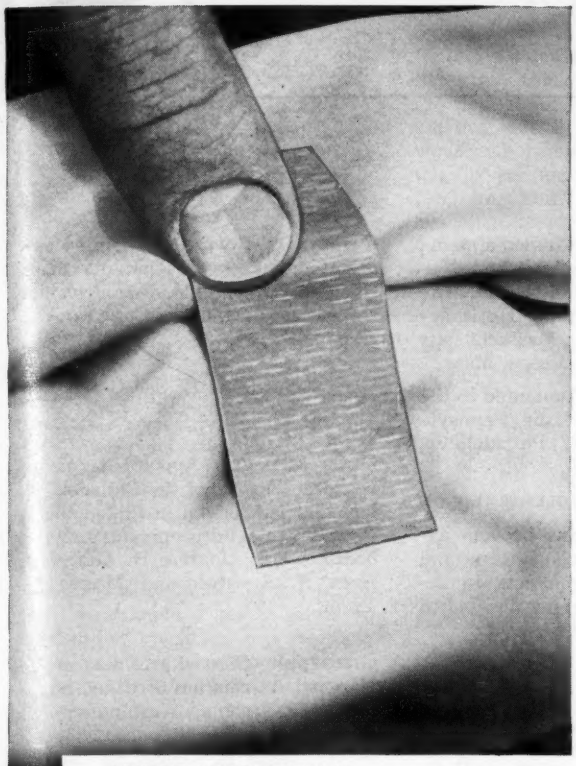
When, therefore, the hospital concludes that the patient is in the convalescent stage and may leave its confines, we have the alternatives of (1) his home; or (2) a substitute for his home, under continuing medical supervision in each case. Having gotten to this point we are in a position to consider what these substitutes might be. They are (1) the mountain, seashore, or farm resort which has such a strong appeal for the weary and heavy-laden; or (2) the convalescent institution, provided that it is limited to, and capable of dealing with, convalescent care, once more under hospital-medical supervision. A convalescent wing within the curtilage of a general hospital, or, in what the British call a "half-way house" at a reasonable distance, would seem to be the best way of dealing with the problem. The important point to influence us here is continuity of care, a sort of standing-guard on the part of the hospital to prevent any interference (human or other) with recovery and to make possible the prompt application of appropriate measures in case of failure or threatened failure. Between the patient's home, the resort, and the institutional substitute, we can find the convalescent patient's way to salvation.

Secondary Institutions

On the negative side we must consider the evil effects of vitiating the effort by transferring the convalescent patient into a slowly dying mass of undesired clinical problems in a secondary institution established to catch the leavings of the acute general hospital. Furthermore, the solution of the problem of the convalescent patient must not be made to depend on such factors as age,[10] economic condition, or any other consideration than the condition of the patient as defined above.

We have outlined here a combined intra-mural and extra-mural organizational plan of dealing with convalescence which, based on a guiding definition which clearly relates it to the other phases of health and medical care, as well as to the various types of existing or desirable institutional facilities, can be made to conform to the highest requirements of the modern physician and sociological idealist. The Home Care program as an extra-mural hospital function was formulated in the first place in response to the need for the individualization of care in any location. It was a more intelligent expression of rebellion against the impersonal, mechanical, routine of hospitals during strictly limited periods of time than the creation of stagnant facilities maintained independently at a distance (the so-called chronic hospital, for example). The financial savings of this program, though highly desirable, were considered subordinate to those objectives which were purely humanitarian. So it is, and so may it ever be, with convalescent care. We are dealing here with a hard-won phase of medical effort and one which must be safeguarded throughout.

Please turn to page 62



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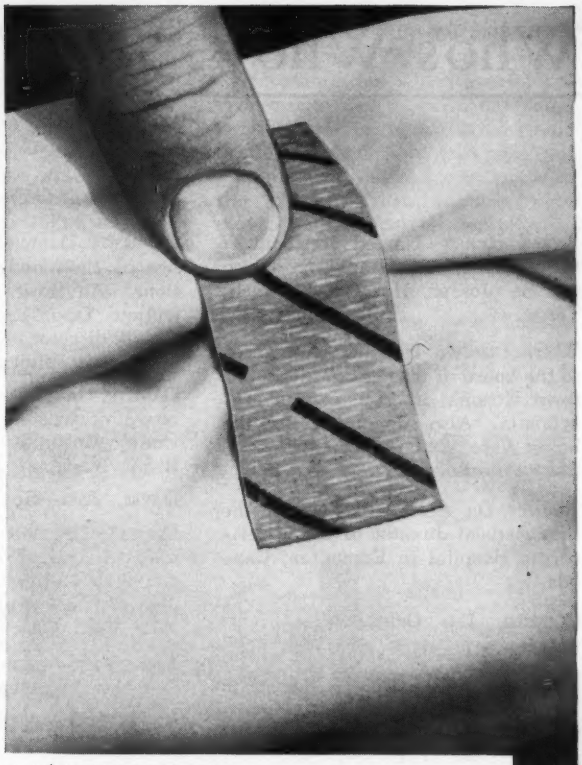

AFTER AUTOCLAVING. These unmistakable markings tell you the pack has been through the autoclave. There is no possibility of error. The special inks used in this tape must be *intentionally activated,* and

Only high steam temperatures can do it!

No danger that sunlight or radiator heat will bring out the distinctive stripes on this foolproof tape. When you see them on an autoclave pack (and they can be seen clear across a room) you're sure that pack has been through the autoclave. *This is not positive proof of sterility, of course—nothing on the outside of a bundle can prove that.*

Seals packs firmly in half the time required for pinning, tying, or tucking! "SCOTCH" Hospital Autoclave Tape No. 222 holds in high steam temperatures, leaves no stains or gummy residue, can be written on with pencil or ink.

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Who's Who

AYRES, HENRY—Named president of the newly organized advisory board for St. Joseph Hospital in Paris, Texas.

BARTHOLEMEW, HOWARD—Appointed to the board of trustees of the Pottstown Hospital in Pottstown, Pennsylvania. Also appointed to the board were: ERNEST T. HANDLEY and SIDNEY POLLOCK.

BRUNET, DR. ARMAND J.—Named the first medical director of the Misericordia Hospital in Edmonton, Canada.

CLINGER, DR. ORRIS—See GATSKI notice.

COOPER, CHARLES F.—Re-elected to his thirteenth consecutive term as president of the Presbyterian Hospital in New York, New York.

CRISCONI, JOHN P.—See LINEWEAVER notice.

CROCKETT, DAVID C.—Named a member of the newly established National Advisory Allergy and Infectious Disease Council. He is associate director of the Massachusetts General Hospital in Boston, Mass.

DALTON, HARRY L.—Appointed to the board of trustees of the Pennsylvania Hospital in Philadelphia, Pennsylvania.

DAVIS, JOEL—See VOLLMER notice.

ERDMAN, ADDISON—Has become associated with Francis Rogers and Jonathan Butler, Architects, in the field of hospital planning, located in New York City, New York.

FOX, VICE-ADMIRAL CHARLES W.—See MARTIN notice.

GASTON, DR. LLOYD H.—Elected president of the Greater New York Hospital Association in New York, New York. He succeeds ALEX E. NORTON.

Reverend E. C. Hofius, retiring after 38 years as administrator of the Lutheran Hospital in Saint Louis, Missouri, was honored by the Greater St. Louis Hospital Council following the Council meeting. Reverend Hofius was presented with a motion picture camera. The Executive Committee of the Council present at the ceremony were: (left to right) W. E. Hennerich, M.D., Hospital Commissioner; David Littauer, M.D., Jewish Hospital; Mrs. Addie Mullins, Christian Hospital; Mrs. Cornelia S. Knowles, McMillan Hospital; Mrs. Hofius; Sister Mary Brendan, RSM, St. John's Hospital and president of the Hospital Council, and Reverend Hofius.

GATSKI, DR. ROBERT—Appointed superintendent of the Danville State Hospital in Danville, Pennsylvania. He succeeds DR. ORRIS CLINGER, who resigned.

GEITCHIK, JOSEPH B. See GENEL notice.

GENEL, SAMUEL—Appointed to the board of trustees of the Philadelphia Psychiatric Hospital in Philadelphia, Pennsylvania. Also appointed to the board were: JOSEPH B. GEITCHIK, ALEX F. STANTON and MONTY H. TYSON.

GILL, JOHN—Elected president of the National Association of Clinic Managers in Tacoma, Washington. He has been clinic manager of the Street Clinic in Vicksburg, Mississippi for many years.

GITLOW, HENRY—See MARTIN notice.

GREER, JOSEPH P.—Appointed assistant director of the Presbyterian-St. Luke's Hospital in Chicago, Illinois, and will serve as administrator of St. Luke's Hospital also in Chicago.

HANDLEY, ERNEST T.—See BARTHOLEMEW notice.

HOLLAND, DR. B. DIXON—Appointed secretary of the American Medical Association Council on Industrial Health in Chicago, Illinois.

HUFFMAN, DAVE—Resigned as administrator of the Muskogee General Hospital in Muskogee, Okla.

JOHNSON, CHARLES M.—Appointed to the board of trustees of the Temple Hospital in Philadelphia, Pennsylvania.

JOHNSTON, ERNEST—See ROBERTS notice.

JONES, EDWARD B.—Appointed assistant administrator of the Sewickley Valley Hospital in Sewickley, Pennsylvania.

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ARNSTEIN

Continued from page 45

2. Demonstrate the procedure.
3. "Return" the demonstration; that is, have the "student" do it.
4. Supervise the "students" practice.

This method is so simple and logical that I think every one of us here today would probably use it naturally, without realizing there are four steps.

The National League for Nursing recommends that the teacher who conducts the institute later should visit those who attended, in their own hospitals. In one state where funds were not available for this kind of follow-up, it is thought that the project has been less successful without it.

The response to the program has been remarkable. Nobody seems to mind minor obstacles, bad weather, inconvenient travel schedules, or extra work. In Minnesota last winter, one of the teachers planned a trip to a northern town. So much snow was falling that morning that she left her car home and traveled by bus. At her destination she found the whole town snowbound and no taxis running. The local police gallantly provided transportation to the hospital. In Montana, a teacher got off the train in a blizzard. Forty-three inches of snow had fallen and the only thing moving was a jeep. The jeep took her to the hospital where she found five trainers had turned out. (We think not more than eight persons should be included in a training group.) It is interesting, enlightening and heartening to hear about this kind of enthusiasm for a project.

This program works best in hospitals where everyone understands and prepares for it. Hospital administrators, doctors, patients, aides, instructors—all have expressed their enthusiasm and pleasure. I've seen some of their letters reporting that where the aides are well trained, the patients are more comfortable and better satisfied. Such expressions more than compensate for weather difficulties or the problems of releasing people from their jobs to attend workshops, and, in fact, most of the hospitals and nursing homes have taken action to overcome any minor difficulties of this sort.

It is typically American to get all whipped up with enthusiasm for a new program. We see this in our advertising. The ads always play up the benefits of something new. In this particular project, now, the important thing is to continue. We are now thinking about this, and a meeting will be held soon to discuss ways and means of assisting hospitals to continue the aide training program. The accomplishments in less than two years make us confident this can be done. ■

MACDERMOT

Continued from page 48

bers of the Nurses Alumnae Association volunteered and many were on hand to sit with the patients in the ambulances. There were three or four patients for whom special arrangements had to be made. These included one in cardiac failure who needed oxygen. The tent was put into the van and a doctor sat with the patient. Fracture cases were moved with their extension apparatus. A special loading ramp was built to allow beds to be wheeled into the vans.

The operation on each Sunday was completed in about three hours and was entirely successful. ■

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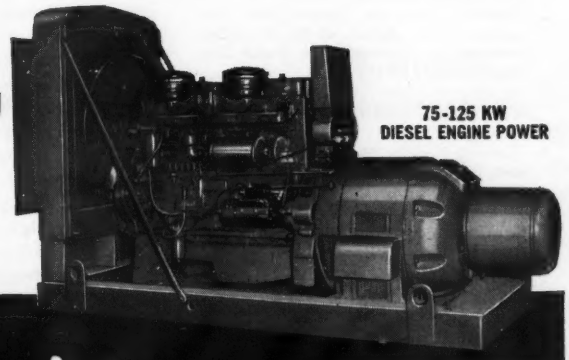

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BG-5

BLUESTONE

Continued from page 58

On the day that we will be convinced of the therapeutic value of individualizing medical problems like these which are so shrouded at the present time in fog, uncertainty, and the apparent willingness to muddle through with them, will be solved. We shall have to recognize the handicap of complete independence of medical care on the one hand and false integration on the other. The physician, and the hospital that supports his efforts, must see the patient unbrokenly in all stages of his difficulty, and plan to protect him at each of them. ■

1. "Planning for the Convalescent Patient" **The Modern Hospital**, June 1940.
2. "Medical Care for Patients with Prolonged Illness" **Annals of the American Academy of Political And Social Science**, January 1951.
3. "General Hospitals — 'Acute', 'Chronic', or Both?" **Hospital Management**, May 1955.
4. "Construction for Medical Care" **American Journal of Public Health**, March 1953.
5. "The Principles and Practice of Home Care" **Journal of the American Medical Association**, August 14, 1954.
6. "Integrating Acute and Chronic in a Combined Hospital-Home Pattern" **The Lancet** (England) December 8, 1951.
7. "Home Care and the Practitioner" **Journal of the American Medical Association**, November 8, 1952.
8. "The Custodial Case and the Chronic Patient" **The Modern Hospital**, March 1956.
9. "Planning for Long-Term Illness" **Medical Clinics of North America**, March 1949.
10. "Medical Care of the Aged" **Journal of Gerontology**, October 1949.

BICKFORD

Continued from page 51

Psychologically, we cannot praise Visit Vision too highly. Unforgettable is the mother who had recently delivered her seventh child, who was thrilled beyond words to have her other six children brought in to visit her—in relays, since all six could not be seen on the TV screen at once! Another mother jumped out of bed to get her lipstick when she heard her son was going to visit her on TV—even though we kept assuring her he could not see *her*, though she could see him!

The patient demand for Visit Vision has been very great. It is not only parents who are enjoying these family chats. One young boy who had had an appendectomy had a TV visit with his young twin sisters, which buoyed him up immensely. ■

SMALLEY

Continued from page 44

Anthropometrics

One of the criteria for determining an optimum height for getting in and out of bed and for administering treatments and care to patients is assumed to be related to the physical dimensions of the body. For the purpose of determining an optimum working height, measurements of nurses were made for over-all height, shoulder to floor, elbow to shoulder, elbow to fist center, elbow to floor, palm to floor, and heel height. In addition, measurements were made using male and female patients and foam rubber and innerspring mattresses for the net increment added to working height by the patient's body and for the effect of mattress deflection. Using the criteria that nurses not be required to work above elbow height and that nurses not be required to bend the body in working, statistical analyses of the distributions of physical measurements yielded a theoretical optimum high position mattress height of 33.8 inches. (Figs. 1 and 2). In order to determine the optimum mattress height for enabling patients to get in and out of bed easily, physical measurements were made of male and female patients, real and simulated, for popliteal to floor distance, foot reach realized by dropping the ball of the foot, and mattress deflection caused by the patient in a sitting position. From analyses of the distributions of such measurements, an optimum low position mattress height of 18.3 inches was determined (Fig. 3). Thus, the optimum distances from top of mattress to floor of the variable height bed would be from 18.3 inches to 33.8 inches, giving a travel of 15.5 inches.

Informed Opinion

In order to bolster confidence in whatever conclusions are drawn from this study, the research team solicited opinions of patients, nurses, doctors and manufacturers with regard to the hospital beds under investigation. Questionnaires were distributed to these groups and follow-up interviews were conducted in some instances.

The consensus of patient opinion seems to be that the variable height bed is at a comfortable sitting height, does not cause difficulty in getting in and out of bed, does not make the patient feel unsafe or uneasy and does not cause undesirable sensations, vibrations, or noises. The patients do not usually raise or lower the bed, but they would like to be able to do so for independence and to be more comfortable. They would also like to be able to raise and lower the back rest and knee rest.

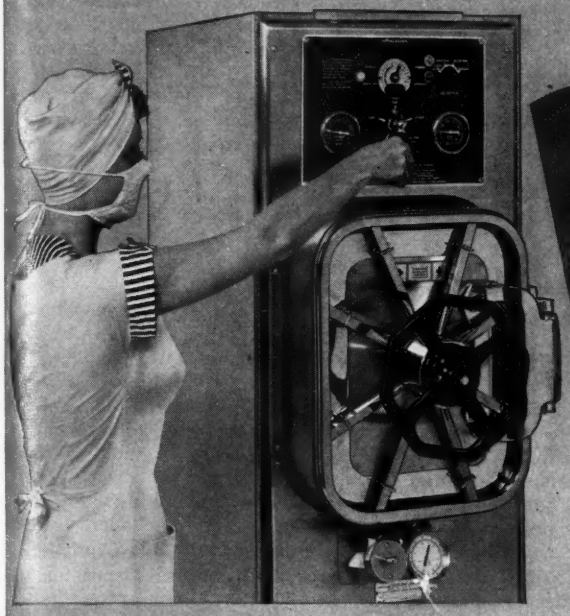
The nurses feel that ambulatory, oriented patients who are able, strong, and not seriously ill and who are not on complete bed rest should be permitted to raise and lower the bed, consistant with the patient's condition. They feel that the switch for the powered bed should be dual, that the speed of raising and lowering is about right, and that it would be desirable to have the average patient raise and lower the back rest. The nurses expressed the opinion that there is enough clearance between the crank and the bed but not enough between the crank and the wall nor the crank and the bedside stand, that the shape of the handle is satisfactory, that too many turns of the crank are required, that the bed is difficult to raise and lower, and that more energy is required to raise the bed when the maximum height is approached. They tend to favor the one-crank bed over the two-crank bed. The nurses report that patients rarely complain of vibrations or noises. The nurses feel that the minimum height is comfortable for the patient's getting in and out of bed and that the maximum height is comfortable for most nursing procedures, although they often leave the bed in a medium height position. There is a feeling among the nurses that the floor space required for the variable-height bed is about the same as that for the conventional bed and that certain changes in attachments and accessories appear to be needed.

The doctors feel that patients, if physically and mentally able, should be permitted to raise and lower the bed with the possible exceptions of psychotic and cardiac patients, and that it would be desirable to have a bed constructed so that patients could raise and lower the back rest, but a majority are opposed to having the knee rest elevated at all.

The manufacturers feel that the switch will last for the life of the electrical system, that it should be replaced, not repaired, that explosion-proof types are available, and that dual controls are not necessary since the switch is portable. They

Please turn to page 92

TO FACILITATE MODERN SURGICAL PROCEDURES AND EFFICIENT HOSPITAL PRACTICE . . .



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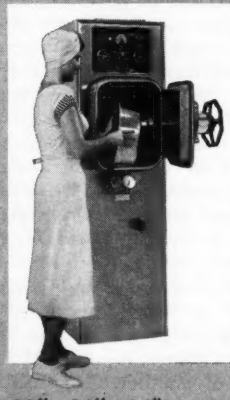
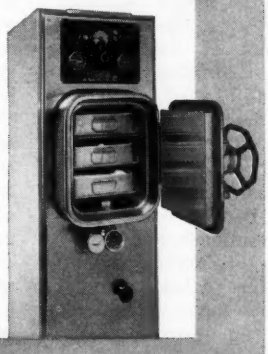


• 12" x 16" x 24" square chamber is large enough for basins and utensils.



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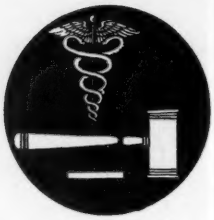
Hospitals and the Law



by Emanuel Hayt, LL.B.

The Administrator and the Board of Trustees

Their responsibilities in preserving hospital assets

Part I

■ DURING THE PAST 50 years there has been a spectacular growth of charitable trusts and foundations. Their expansion and development has created problems of supervision and trustee accountability. In more than half of the states in this country there is no provision for maintaining a list of charitable trusts; the attorneys general in these states do not periodically inspect charitable trusts to see that their purposes are carried out properly. Such supervision is primarily a state function, except where the Federal government demands income-tax reporting.

Foundations owe a full and complete accounting of their activities to the public, particularly to justify their tax-exempt status. In line with this responsibility, new laws are being enacted which seek to control solicitation and to require accounting of the expenditure of such charitable funds. The pattern is for the charitable organization to register with a state agency before commencing a fund-raising campaign, by filing a statement containing appropriate information as to its officers and purposes.

The registration of agencies engaged in the solicitation of gifts is intended to eliminate the small minority of organizations and promoters who abuse public confidence. An annual report required to be filed showing financial operations for the prior year provides information to contributors and to government.

There are literally thousands of private charitable agencies in this country which support good and constructive works of all kinds, including voluntary hospitals. They are financed by millions of Americans who gladly give of their substance to help their fellow man.

Voluntary hospitals, like other charitable agencies, have grown in number during the past half century. Many of them have expanded into great medical centers, affiliated with medical colleges, schools of nursing, and other specialized health units. The financial investment in these great centers rivals that of many sizeable industrial plants. The destinies of such health agencies and their vast funds are entrusted to the judgment of civic-minded citizens experienced in many fields of endeavor, who control and direct the operations and policies of these organizations.

Contributions to hospitals have become an important part of the philanthropic budgets of many business corporations and show every evidence of increasing with time. Corporations realize more and more that they have community responsibilities in providing the support of hospitals. It has been demonstrated in a recent survey of industrial corporations that 71 percent gave contributions to operating budgets of hospitals and 75 percent contributed to capital funds for new buildings, modernization, expansion, etc. Recently, the Ford Foundation made the largest gift to hospitals throughout the country ever granted by a philanthropic trust.

It should be no surprise that the public and the state authorities are becoming more interested in knowing how and for what purposes these funds are spent. Contributors want to be assured that proper legal safeguards exist against the improvident use of their gifts. They want to know that the funds of community services, such as hospitals, are in good hands.

Trustees and Trust Funds

The management of the affairs of a non-profit hospital corporation is vested by its charter or articles of incorporation or by state law in a board of directors. The mere fact that they are called trustees rather than directors or governors does not imply that they are the trustees of a trust fund. Unfortunately, much confusion has been caused by designating the board of directors of a hospital corporation as the trustees of the hospital. In the strict legal sense of the word, the trustees of a hospital are not the trustees of a trust fund but are merely directors of the governing board of a corporation.

What is a trust and what is a trustee? A "trust" is created when property is given to one with a direction that it be applied for the benefit of another. A philanthropic or charitable trust has three elements: (1) the donor of the fund or property; (2) a trustee who is competent to receive it; (3) a charitable purpose for the gift and a definite beneficiary. The trustee of the fund may be a trust company, some individual, or a corporation receiving property or money to administer.

The broad definition of a trustee provides that *"the expression trustee of any charity shall mean and include every person and corporation seized or possessed of or entitled to any real or personal estate, or any interest therein, in trust for,*

or for the benefit of, such charity, or all or any of the objects and purposes thereof, and every member of such corporation."

In practice, every person is deemed to be a trustee to whom the business and interests of others are confided, and to whom the management of their affairs is entrusted. One becomes a trustee to whom title or ownership of property has been transferred arising out of a confidence reposed in him to apply the property faithfully and according to such confidence.

It is true, of course, that many hospitals have trust funds. They also have endowments and general funds. But the property or other assets of a hospital do not necessarily constitute a trust unless the real or personal property comes within the legal definition of a trust and the person who manages the property has been appointed the trustee by the donor of the fund. A hospital corporation, as such, may be the trustee of a particular trust fund when it meets the elements of a trustee relationship.

Endowments

Endowments are trusts set up for charitable, educational, scientific, or religious purposes. Some come as gifts by bequests in wills; others by contributions given during the donor's lifetime. Some donors prefer to establish a memorial endowment fund to be maintained in perpetuity, with only the income available for use. Others provide for the use of the capital as well as interest within a specified or unspecified number of years.

Endowment funds may consist of cash, bonds, stocks, mortgages, and real estate. Money given for the erection of hospital buildings is not an endowment, but a gift. An endowment is income producing, as by interest on bonds, mortgages and loans, dividends on stocks, and realty rentals. Such endowments should not be confused with simple gifts which may be applied for budgetary or nonbudgetary purposes during a given year, or at some future time. Outright gifts are "temporary" funds, and not restricted capital endowments.

Endowments may be either (1) unrestricted or general, or (2) restricted or special. Income from unrestricted or general endowments is available for any proper use. Income from restricted or special endowments may be used only for the purpose designated by the donor.

Long guards often cause accidents
shortguards prevent them!

reduce bed falls with the—

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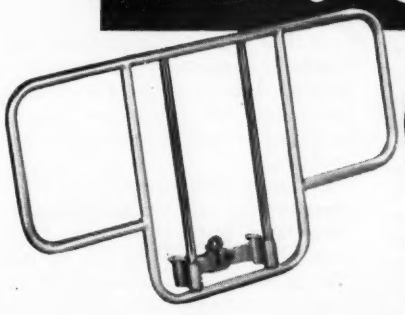
Safety Side



easily applied

to any type of wood or metal bed, including the adjustable high-low beds.

● The purpose of any sideguard, of course, is to prevent the patient from falling out of bed. The fact is, however, that the long side guards that have been commonly used may—and often *do*—serve to make a fall more serious, rather than to prevent it. If the patient insists on getting out of bed, and has the physical strength to do so, the *long* guard will not prevent him. It is the consensus of hospital people who have seen and used the Hill-Rom Safety Side that it will take care of 98% of all cases requiring side guards. The comparatively few cases that may require a full length sideguard can be taken care of by affixing another pair of Safety Sides to the foot end of the bed.

Safety Sides—A New Safety Measure
by Alice L. Price, R. N., M. A.
author of "The Art, Science and Spirit of Nursing"
This Procedure Manual explains in detail how to effectively use Safety Sides to prevent bed falls and to avoid serious injury to patients. Copies for Student Nurses and for the Graduate Nurse Staff will be sent on request.

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Unconditional gifts and bequests which permit the use of both principal and income should not be intermingled with endowments, nor classified as such, since the latter are trust funds. Nor should endowments be commingled with general funds. "Once endowment, always endowment," should be the rule. Unrestricted general funds are general assets of the hospital and not trust funds.

Ownership and Management of Hospital Property

The trustee who is a member of the board of directors of a non-profit hospital corporation has no title or ownership in the corporate property. The concept that title vests in the trustees of a non-profit hospital corporation is erroneous. A corporation, despite the fact that it is said to be an artificial being, which is invisible, intangible and exists only in contemplation of law, created either by the state or federal statute, has the right to own, acquire and transfer property in its own name. Among the attributes of every corporation are immortality and individuality; it may own and sell property; it may make contracts; it may sue or be sued; it enjoys certain other privileges and immunities.

The fact that the trustees or directors act as the agents of the corporation or for the purpose of transferring property does not mean that the property belongs to them. When the term of a trustee expires, he no longer has any right to act in behalf of the hospital. Certainly, it cannot be said that he is owner of an undivided share of the property while he is a trustee, but immediately upon ceasing to be a trustee he has forfeited his ownership. When a trustee dies during his term of office, the hospital property does not pass to his heirs or become part of his estate. One who owns property continues to own it so long as he has title and survives.

The directors, of course, are not mere servants of the corporation; they are the controlling powers of the corporate body, representatives acting and standing in the place of all interested parties. As directors, they constitute its thinking and acting capacity with general superintendence and active management of all the activities of the corporation. What they do as the representatives of the corporation, the corporation itself is deemed to have done.

The Joint Commission on Accreditation of Hospitals scrutinizes the management of the hospital as part of its survey. Among other things, it is interested in (1) whether there is an organized governing body responsible for the overall functions and management of the institution; (2) whether the responsibilities of the trustees are clearly established in the hospital bylaws; (3) whether the governing board is composed of representative members of the community and are elected or appointed to office as a result of their genuine interest in the welfare of the institution; (4) whether any of the members of the board of trustees gain personal benefits through their association with the hospital; (5) whether the board holds regular meetings and minutes are kept on all proceedings of the board.

These requirements of the Joint Commission cover many of the legal responsibilities of the hospital trustee not only for the administration of the hospital, but also for the preservation of its assets.

The Ideal Trustee

Dr. Anthony J. Rourke, a past president of the American Hospital Association, more broadly gives the qualifications for the ideal trustee as follows:

1) The trustee should have community approval. His proving-ground days were spent in other community services where he established respect, confidence and approval.

2) The trustee should have sufficient time to give to his studies and obligations. If he is one who wants to get by with as little time as possible given to his trusteeship, arrives late at meetings and grumbles all during the meeting, leaving before it is over, he would be happier in some other endeavor.

3) The trustee should have a consuming and continuous interest. In other words, he should keep the hospital's interest in mind at all times and not forget it between meetings.

4) The trustee should be able to differentiate between policy making and execution. If he cannot he would probably be happier as a hospital administrator than a hospital trustee.

5) He should have the courage to make unpleasant decisions when they are necessary. This does not mean making unpleasant decisions unpleasantly but firmly and judiciously in accordance with good judgment.

6) The trustees should never allow popularity to take precedence over prudence. The saying that a man who pleases everyone never does anything may not be wholly true but has a certain degree of merit in it which can apply to hospital trustees.

7) The trustee should be a participant and not merely an attendant at meetings of the board of trustees. He should take part in evolutionary actions, not revolutionary decisions. He should not be an obstructionist.

8) The trustee should have acquired that spark of humanity in his heart which allows him to evaluate his actions by the good accruing to others, not to himself. He should understand human relations and practice the motto: "Service not self."

9) The trustee should be able to thrill to medical miracles in his house of healing even more than he thrills over the beautiful lobby that his wealth and generosity have made possible. It is not marble, bricks and mortar, important as they are, that make a hospital; it is the service to humanity when ill or injured that means most and which the trustee must realize.

10) The trustee should be a general practitioner of his trusteeship, not a trustee specialist. Special skills are valuable but they can be purchased. Trustees cannot afford to develop telescopic vision in carrying out their responsibilities. They must see and meet their responsibilities at all times.

This is part I of a two part article. Part II dealing with duties of trustees, administration of investments and obligation of administrators will appear in the August issue.

". . . and we are reinstating the rule regarding visitors under 14."

WHO'S WHO

Continued from page 60

JONES, JENNINGS—See PALMER notice.

KEOGH, JULIE I.—See TREWHELLA notice.

KLICKA, DR. KARL S.—Appointed director of the new Presbyterian-St. Luke's Hospital in Chicago, Illinois. He was formerly director of the Presbyterian Hospital in Chicago, Illinois.

Dr. Leveroos

R. A. Lorini

LEVEROOS, DR. EDWARD H.—Named director of the Ochsner Foundation Hospital in New Orleans, La. DR. LESTER L. WEISSMILLER, director of the hospital since 1947, who resigned to accept a position in the Veterans Administration, will move to Chicago in early June.

LICHTY, DR. JOSEPH S.—Director of the Cone Memorial Hospital at Greensboro, North Carolina, has resigned, effective July 1.

LINEWEAVER, (MRS.) THOMAS H.—Appointed to the board of trustees of the Philadelphia General Hospital in Philadelphia, Pennsylvania. Also appointed to the board were: MRS. I. J. K. WELLS and JOHN P. CRISCONI.

LORINI, RALPH A.—Appointed controller of The Roosevelt Hospital in New York City, New York.

MABOLL, PHILIP—See STEVENSON notice.

MACER, DAN J.—Appointed manager of the Veterans Administration Hospital at Sunmount, New York.

MARTIN, DR. WILLIAM—Appointed to the board of trustees of St. Luke's Hospital in Philadelphia, Pennsylvania. Also appointed to the board were: VICE-ADMIRAL CHARLES W. FOX, USN (RET.) and HENRY GITLOW.

NEVEL, DR. HARRY—Resigned from the American Hospital Association's survey staff in Chicago, Illinois.

NORTON, ALEX E.—See GASTON notice.

David L. Odell

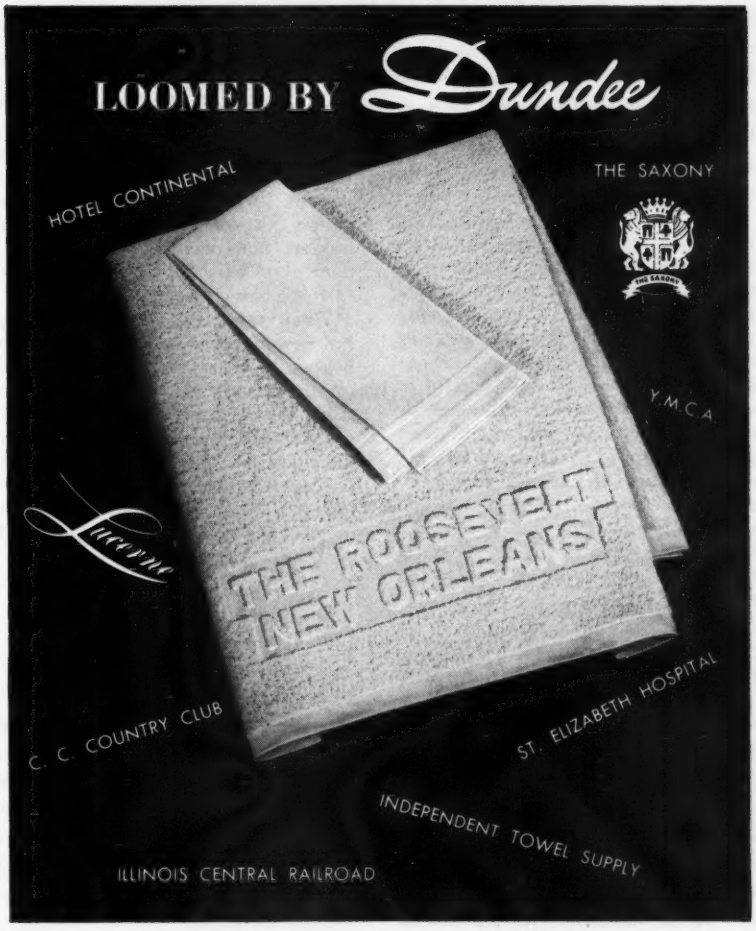
ODELL, DAVID L.—Appointed assistant director of the Rancho Los Amigos Hospital in Hondo, California. He was formerly assistant administrator of the Methodist Hospital of Southern California.

PALMER, RICHARD—Named president of the Rutherford Hospital executive board in Murfreesboro, Tenn. He succeeds JENNINGS JONES, whose one year term had expired.

POLLOCK, SIDNEY—See BARTHOLEMEW notice.

ROBERTS, PHYLLIS—Appointed superintendent of the Greene County

Please turn to page 109



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Medical Records

by Edna K. Huffman, C.R.L.

Average Length of Stay

***QUESTION*: We have an annex for our geriatric patients who stay a long time before they are discharged, or die. If I combine their discharge days with those of patients discharged from the general hospital the average length of stay is long. This of course does not give an accurate picture of the hospital stay for patients from the general hospital. In a case such as this could I use their census or in-patient days, instead of discharge days? S.M.J.**

ANSWER: I would figure the average length of stay for geriatric patients, separately from that for patients in the general hospital, and use discharge days for both. This is the only way you can have an accurate picture of the length of stay of your geriatric patients as contrasted with the patients in your general hospital. You could not get a true picture if you use your census days. These figures should be used to figure the daily average number of patients for the hospital as a whole, and/or by services when necessary.

Numbering Medical Records

***QUESTION*: We are successfully using the serial method of numbering in our hospital. However, should we not give a new number to each admission even though discharged only a few days previously? Also, how far should we number before starting a new set of numbers? We are now at 103600. M.H.**

ANSWER: It is customary to number to 999,999 before starting a new numbering series regardless of the method used. After reaching 999,999 there will be no confusion in filing even though you start over with 1 and work up again to 999,999. The prefixing of letters or two digits representing the year is not considered good medical records practice as it leads to confusion and filing errors.

You mention that you are having success with the serial method of numbering. I would suggest that you carry this one step further and use a serial-unit system of filing. With this method the patient is given a new number on each admission (a serial number) and all previous records are brought forward and filed together under the last number thus attaining a unit record. This method has all the advantages of the serial method, and in addition provides a unit record for use of the doctor when caring for the patient. In addition, it brings all the active records to the front of the file so that when microfilming is done it is only the inactive records that are being filmed.

When using this method of filing the new number to which the chart is going must be recorded on the old folder leaving it in the file as a guide to that particular medical record. If needed, at any time, and the old number is the only one at hand, the record can easily be traced. If the old folder is not used for this purpose some other type guide must be used.

Time Required to Keep Registers

***QUESTION*: We are in the process of changing storerooms and wonder how long we must keep the following: surgery books (listing operations by day of surgery performed); labor room books (listing of every mother delivered by date of delivery); and books listing the admissions and discharges by name. I.M.P.**

ANSWER: I personally feel that Admission Registers should be kept forever although I have neither seen nor heard of requirements regarding this. Even after they are no longer needed for patient information they are a valuable record of the work of the hospital, and eventually become an historical document. If you have Admission Registers in your hospital the listings of admissions and discharges need not be kept; otherwise they should be kept for the same length of time as Registers because, in effect, the listing of admissions in chronological order is a patients' register. You will probably never need the data on discharges, while that on admissions is valuable in many ways including as a number index.

While I know of no definite regulations concerning the length of time that Delivery Room and Operating Room Registers should be kept I feel that ten years would be adequate, in this day of improved medical records. Years ago medical records were so inadequate that these registers needed to be kept for longer periods while today they are mainly used currently and for research projects. While research projects rarely cover more than a ten-year period many do cover such a term, therefore, much time can be saved by keeping and using these registers for such a period, instead of the indexes or medical records when a time element is involved.

No Autopsy Credit on Patient Dying at Home

***QUESTION*: Can an autopsy, performed by the hospital pathologist, ever be credited to the hospital if the patient died at home even though hospitalized on several occasions? T.H.B.**

ANSWER: As far as I know there are no exceptions to the fact that autopsies must be performed on patients dying in the hospital when counted in the autopsy percentage.

Authorizations on Minors

***QUESTION*: Is it necessary for both parents to sign a consent for operation on a minor? A.E.C.**

ANSWER: It is not general practice to have both parents sign the consent for operation on a minor unless there are specific laws to the contrary in your state. In those states

Please turn to page 87

How to select a New Kodaslide Projector!

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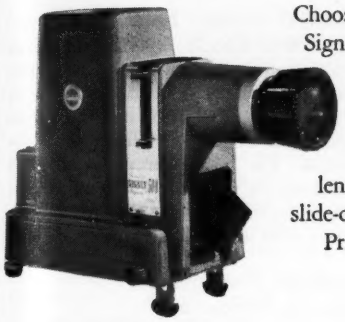

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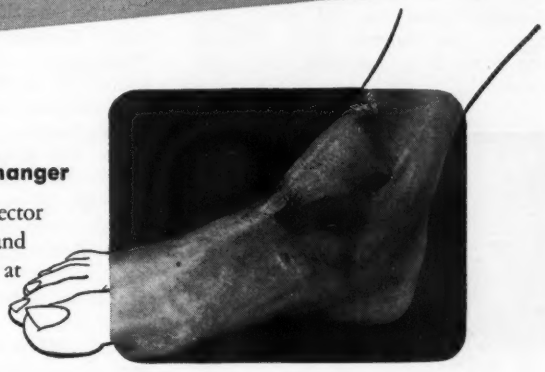

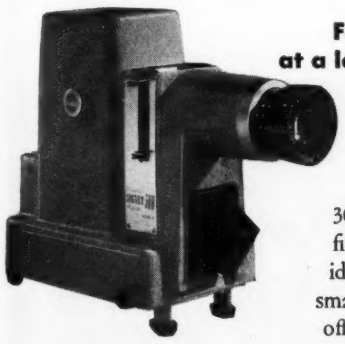

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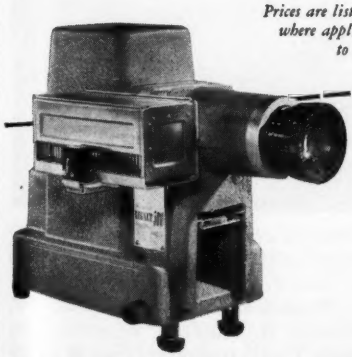

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What Associations Are Doing

Tri-State Hospital Assembly Presents Achievement Awards

■ THE PRESIDENTS of the state hospital associations of Illinois, Indiana, Michigan and Wisconsin presented awards for outstanding service to the hospital field to a nominee from each of their states at the twenty-sixth annual banquet of the Tri-State Hospital Assembly at the Palmer House in Chicago. Similar awards, consisting of gold pins bearing the insignia of the Assembly have been presented annually since 1949.

R. H. Duncan

M. E. Woodard

B. D. Dann

Msgr. Goebel

The 1956 award winners are: Illinois: Russell H. Duncan, administrator, Carle Memorial Hospital, Urbana; Indiana: Maude E. Woodard, Kokomo, treasurer, Indiana Hospital Association; former administrator, Clinton County Hospital, Frankfort; Michigan: B. D. Dann, administrator, Hackley Hospital, Muskegon; Wisconsin: Rt. Rev. Monsignor Edmund J. Goebel, superintendent of schools and director of Catholic hospitals, archdiocese of Milwaukee.

Southeastern Hospital Conference

■ NEW OFFICERS of the Southeastern Hospital Conference are R. E. Blue of Willis-Knighton Hospital, Shreveport, La., president; Pat N. Groner of Baptist Hospital, Pensacola, Fla., president-elect; and Robert Ivy, Doster Hospital, Columbus, Miss., vice -president. An executive secretary-treasurer will be named by the Conference Board of Directors to succeed Pat Groner. Next year's meeting will be in Atlanta, Ga., in April.

North Delta Hospital Council

■ AN INSTITUTE on Combatting Fire, Smoke, and Explosions was held at the General Hospital, Greenville, Mississippi. Dabney P. Gilliland, Chairman of the North Delta Hospital Council, officiated.

The program included demonstrations and discussions of types of fires, the hazards involved and methods of combatting them. The meeting was attended by personnel from Mississippi Hospitals.

Alpha Delta Mu Honors Leo Lyons

■ THE 1956 ANNUAL Tri-State meeting of the Alpha Delta Mu Fraternity was held on April 29th. The agenda included presentation of the National A.D.M. Honorary Award for 1956 to Leo M. Lyons, who upon his retirement March 31st as director of St. Luke's Hospital was appointed executive director of the American Protestant Hospital Association. He has been active in the Program in Hospital Administration since its inception in 1943 and has a son who is a graduate.

American Protestant Hospital Association

■ AT A MEETING OF THE Board of Accreditation it was voted to make the following change in the Standards of Accreditation with the stated limitations and time specified.

All chaplains who have had five years or more of experience in an institution prior to Feb. 10, 1955 and who apply to the Board before Feb. 1, 1957 will have their applications considered for accreditation.

The Board will review past applications which have been rejected on the grounds of training or experience to see if they can be reconsidered under this clause. Such

Officers of the Association of Western Hospitals are: A. E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, Calif., president; F. O. McVey, administrator, Clovis Memorial Hospital, Clovis, New Mex., second vice-president; Wesley G. Lamer, administrator, Physicians and Surgeons Hospital, Portland, Ore., first vice-president; Howard B. Hatfield, administrator, Long Beach Community Hospital, Long Beach, Calif., treasurer; Guy M. Hanner, administrator, Good Samaritan Hospital, Phoenix, Ariz., president-elect.

applicants will be notified if there is any change in their status.

The present Standards for Accreditation are in no way changed by the above statement. These are as follows:

1. College and Seminary degrees or their accepted denominational equivalents.
2. Ordination or appropriate ecclesiastical commissioning and evidence of good and regular standing in a denomination.
3. The successful completion of 24 weeks of Clinical Pastoral Training (some equivalent may be accepted).
4. Three years of parish experience or its equivalent.

The next meeting of the Board will be in Sept. 1956. All applications and inquiries should be addressed to the Chairman, Chaplain Lloyd E. Beebe, Boston City Hospital, 818 Harrison Ave., Boston 18, Massachusetts.

South Dakota Hospital Association

■ ROBERT W. BECKWITH, administrator of the Community Bailey Hospital at Chamberlain and president of the South Dakota Hospital Association was awarded the South Dakota Junior Chamber of Commerce Distinguished Service Award. Since 1948, when Mr. Beckwith became administrator of the Chamberlain hospital, a new hospital building has been built and one new addition added. Plans are now under way for a nursing home to be constructed in connection with the hospital.

The Rev. John J. Flanagan, S.J., executive director of the Catholic Hospital Association, congratulates three new members elected to Council of Conference of Catholic Schools of Nursing. Left to right are Sister M. Camille, R.S.M., director of the Mercy Central School for Practical Nurses, Springfield, O.; Sister Marian Catherine, S.C., director of St. Vincent's School of Nursing, New York City; and Sister St. Catherine, S.S.J., director of St. Mary's School of Nursing, Waterbury, Conn.

Michigan

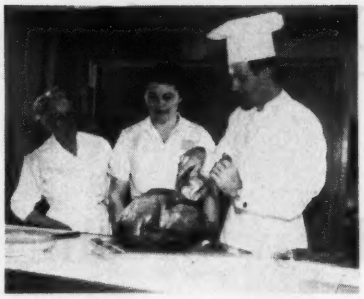
■ Twenty-five food supervisors in Michigan hospitals took advantage of the ten-week course in food service work at Michigan State University.

Plans for the course have been in the making for more than two years by the Michigan Hospital Association and the Michigan Dietetic Association working with Michigan State University. Realization of the course was made possible from a $45,050 grant from the W. K. Kellogg Foundation, Battle Creek, to be used on a three-year basis.

The ten-week course is broken into two segments. The trainees completed the first nine weeks of intensive training in May. The following six months they will put into practice their newly gained knowledge in their own hospitals. During this time, the course coordinator, Margaret Gillam, will visit them to help them solve their individual problems. Then, in October, all the trainees will return to Michigan State for a final week of training and to receive their certificates.

While the 25 trainees have been on the M.S.U. campus, they have had instruction in all phases of food service work. They have used the foods laboratories in the home economics building as well as becoming familiar with the large kitchen setups of the campus dormitories. Another facility they have been fortunate to use is the Kellogg center, M.S.U.'s hotel laboratory.

With many of the Michigan State staff acting as teachers for the group, the 25 students learned such things as: purchasing, nutrition, menu planning, sanitation, safety, communication skills, food preparation and personnel management, including supervisor and job training techniques.



Carving 25 pound turkey is one of techniques being learned at food service training program at M.S.U.

Beaters, measuring cups and other "big" small equipment save much time in preparing hospital meals.

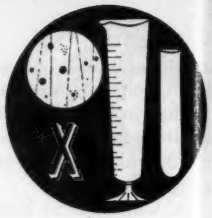
Trainees learn to prepare chicken and roast beef in supervised classes.

Catholic Hospital Association

■ THE RT. REV. MONSIGNOR JOSEPH B. BRUNINI was elevated to the post of president of the Catholic Hospital Association of the United States and Canada during the annual C. H. A. convention in Milwaukee, Wis. The Association, with headquarters in St. Louis, Mo., has a membership of 1,092 general and special hospitals and 394 allied agencies, giving it a total bed membership of 237,448. Msgr. Brunini, pastor of St. Peter's Church, Jackson, Miss., and director of the Mississippi Catholic Hospital Association, is an active personal member of the Mississippi Hospital Association and is currently serving on its Council on Government Relations.

New Mexico

■ THE REV. ROY E. TURLEY of the Espanola Hospital was named president-elect of the New Mexico Hospital Association. Ray Woodham, administrator of Presbyterian Hospital in Albuquerque, is the association's president for 1956. Other officers are Sister Mary Adolpha of St. Francis Hospital in Carlsbad, vice-president; and F. O. McVey of Clovis and Elmer E. Zaudke of the Santa Fe Railway Hospital in Albuquerque, trustees. James E. Jenkins of Bernalillo County-Indian Hospital was re-elected treasurer. ■



How Much Work is Done in Your Laboratory?

Here is a work unit that offers an accurate measurement of laboratory activity

by D. Hugh Starkey, M.D.

▫ IN ASSESSING LABORATORY ACTIVITY, hospital administrators and directors of laboratories have been in agreement for a number of years on the subject of records. Records kept in the form of numbers of specimens examined, are valueless except for making comparisons of activity of the same laboratory from month to month or year to year. Even from such a limited point of view, the value is open to question because changes in medical knowledge alter the types of test demanded and technological changes alter laboratory capacities. As a consequence, various administrative authorities have developed other means of record keeping, particularly for laboratories forming parts of greater organizations such as the Canadian Public Health Laboratory Services, the Emergency Medical Service laboratories in Great Britain during World War II and the Armed Services of different countries.

Towards the latter part of World War II (1942-1945) when administering the medical laboratories for the Royal Canadian Navy, I found that it was necessary to assess actual work loads in a number of different laboratories — some in centers dealing mostly with relatively uncomplicated acute infections and accidents — others in centers dealing with all kinds of illness, including full investigations of cases for medical discharge, etc. My main concern in assessing these various work loads was one of technical man power. Therefore, the initial approach to the revision of records was made on the basis of comparative technical time requirements.

Because laboratories were accustomed to recording their work in terms of 45 different categories and because these categories had proven their worth for indicating the type of work being demanded by the clinical services, it seemed desirable to superimpose weighting factors on to the existing system rather than to start a new one.

Mass Production Tests

It was simpler to pick some very common "mass production" types of test for unity. So, routine Haemoglobins, Sedimentation rates and White Blood Cell counts were chosen. Technicians of varying experience were observed and outputs recorded in the different laboratories in order to arrive at comparative ratings in terms of technicians' time. Since the start of this system, one of the major guiding principles has been to group tests into categories so as to keep bookkeeping requirements down to a minimum. Consequently, some examinations may be placed in a group scored as 3 units each, even though a careful analysis might give such examinations a rating of 2½ or 3½ units.

The unit system begun in the Naval Service was revised in 1947 to suit the somewhat different conditions pertaining in the hospitals of the Department of Veterans' Affairs, which became my responsibility in 1945 when this service was completely reorganized. The most recent revision of the system was adopted in 1955 and the present "work unit" scores are shown in the first column of Table I (Dept of Veterans Affairs).

Some Limitations

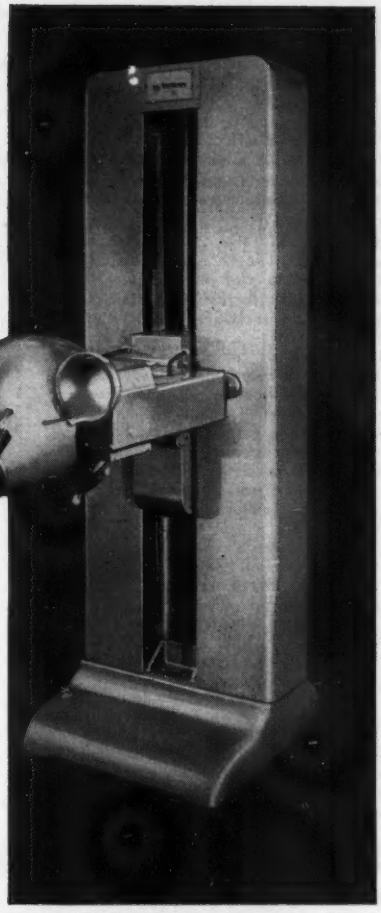
At the present time these units give a reasonable picture of work load in terms of technical manpower as long as the following limitations are clearly understood:

1. The professional work of Pathologists, Biochemists and Microbiologists is not included.
2. A number of duties performed by technicians such as assisting with autopsies and caring for gross tissues are not included. Also, various supervisory duties are not included.
3. No attempt is made to compensate for various imponderable factors which are responsible for apparent differences in technician productivity as between large and small laboratories. Examples of these imponderables are seen in such things as time lost when changing over from doing a few of one type of test to doing a few of a different type, rather than occupying a whole day doing the same type of work; the greater amount of time lost per technician in small laboratories in answering telephones, explaining results, etc.

The last two named limitations make it necessary to expect more units of work from technicians in larger laboratories when compared with those in smaller laboratories. Up to 1954, our experience in the Department of Veterans' Affairs indicated that our smallest laboratories with 6 to 8 technicians were running efficiently if they averaged 1600 to 1700 units per month

Dr. Starkey is Advisor for Laboratory Services of the Department of Veterans Affairs, Government of Canada, in Ottawa, Ontario.

GREAT NEW WEAPON FOR AN OLD BATTLE!



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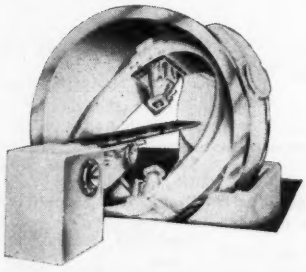

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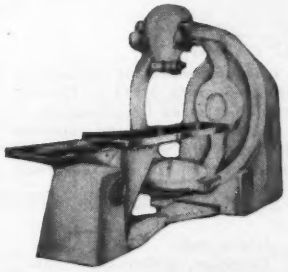

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medium intensity and high intensity units, single shield. Available with or without primary beam absorber, this unit also features precision rotation, adjustable collimators and light beam localizer.

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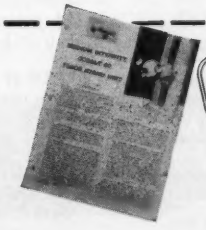

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Table I

WORK UNITS

	DVA[1]	DBS[2]	OPH[3]
A. CLINICAL LAB.			
Urinalysis — routine	1	1	3
— with microscopic	2	2	6
— quant. sugar only (diabetics)	1	1	2
Stools — appearance, occult blood, etc.	1	1	4
Specimen collection on wards (per patient)	1	1	2
B. HAEMATOLOGY			
WBC counts, Sed. rates, Haematocrits, Hgbs. (each)	1	1	2-4
Bleeding, clotting, clot retract. times (each)	1	4	4-8
Spec. Grav. tests for Plasma protein	2	2	4
Special cell counts (CSF), Platelets, etc.	3	2-4	4-8
Prothrombin times	3	2	5
Red cell fragilities (or other titrations)	4	4	8
Differential cell counts on stained smears	4	2	4
Bone marrow differentials & other specials	6	6-8	
C. PARASITOLOGY			
Blood examinations (malaria, etc.)	7	2	4
Stools — concentration &/or search for Helminths, ova, Entamoeba	10	2	10
— fixed smear (Hoematoxylin)	3	—	—
Special exams (cultures, tissues, etc.)	8	—	—
D. MYCOLOGY			
Microscopic search of specimen	5	4	2
Cultures — for isolation	5	8	18
—full identification	15	—	—
E. BACTERIOLOGY — IMMUNOLOGY			
Stained smears without culture (Vincents, Gc., etc.)	1	1	2
Dark-field, Phase or Fluorescent micro.	5	1	2
TB conc. — with smear exam. only	4	—	6
— with smear and culture	8	10	12
General cultures, aerobic, anaerobic (each)	8	6-8	6-18
Antibiotic sensitivities — screen test (disc)	1	2	—
—full testing	3	6	80
Standard Serological studies	5	6	6
Milk, water standard analyses	4	8	4
Animal inoculations, examinations (each)	8	10	12
Special studies, autogenous vaccines, etc. — up to	15	12	40
F. HISTOPATHOLOGY			
Autopsy or Surgical slides (each)			
— routine stain	4	4	10
— special stain	10	—	30
Frozen sections	3	—	—
Exfoliative cytology	6	—	—
G. PATHOLOGICAL CHEMISTRY (See Table II)			
Routine tests (Group 1)	4	2	4
Special tests (Group 2)	6	6	8
Special test (Group 3)	8	8-12	12
Functional test series (run by technicians)	15	12-20	12
Animal tests (A-Z, Frog, etc.)	15	—	40
BMRs	8	4	—
H. BLOOD TRANSFUSION			
Red Cross — specimens from patients sent	1	—	—
— bottles of blood rec'd.	1	—	—
— bottles of plasma issued	1	—	—
Other — donors examined and bled	10	—	—
— Grouping, typing & cross-match (each blood)	15	6	—
I. SEROLOGY			
— single screen test	1	1	1
— routine precipitin or flocculation	2	1	2
— routine complement fixation	4	1	3
— quantitative tests	5	4	—

[1]Department of Veterans Affairs
[2]Dominion Bureau of Statistics
[3]Ontario Public Health

per technician, while the largest laboratories with 25 to 30 technicians should show up to 2000 or 2200 units. In general, the mean was about 1900 to 1950 units per technician per month and the range as between small and large laboratories was ±13 percent.

Methods Improvement

The revision of 1955 was overdue in that our work unit scoring had not kept pace with mass production methods in some of the most common tests — notably Flame photometry for blood electrolytes and Antibiotic testing of bacteria. Since revising these scores the returns have been more realistic and the range in work units per technician per month as between small and large laboratories has been narrowed to ±10 percent.

In the cost accounting field, other variables and some obvious lack of uniformity in methods of charging as between different hospitals make comparisons difficult, but costs up to 1954 when reckoned in terms of work units at least showed the largest laboratories with the lowest unit costs and the others ranged in order of size. From smallest to largest, the range was ±23 percent from the mean. It is hoped that this will be narrowed down when the effect of the new units can be assessed.

Table II

PATHOLOGICAL CHEMISTRY

The following grouping of tests is recommended for the purpose of "work unit" scoring. The all-inclusive scoring of 15 or 20 units for a Functional test procedure must be reserved for procedures in which the administration of test substances, timing and specimen collection is all run by the technicians. If the entire procedure is not run by technicians, the individual chemical test involved should be scored separately.

GROUP I (4 units per test)

- Bile, Bilirubin, Van der Berg
- Brom-sulphthalcin
- Cephalin-Cholesterol flocculation
- Chloride
- Creatinine
- CO_2 Combining power
- Congo Red
- Glucose, Galactose
- Icteric Index
- Potassium, Sodium (by Flame photometry)
- Sulphonamide levels
- Thiocyanate
- Total proteins in plasma or serum (spec. gravity methods)
- Thymol Turbidity or flocculation
- Urea Nitrogen
- Urobilinogen — quantitative

GROUP II (6 units per test)

- Analysis of stones — urinary, gall-bladder, etc.
- A/G ration with total protein
- Nitrogen, total
- Oxy-, met-, sulph..haemoglobins
- Amylase
- Ascorbic acid
- Barbiturates
- Bromide
- Calcium
- Creatine
- Fats, total in faeces
- Gastric Analysis (standard)
- Phosphatase — acid or alkaline
- Phosphorus
- Potassium or Sodium (by chemical methods)
- Protein Nitrogen, total
- Pyruvic acid
- Salicylic Acid
- Thiamine
- Urobilinogen, quantitative

GROUP III (8 units per test)

- Alcohol
- Amino-acids
- Cholesterol, fractionation
- Fats in faeces, fractionation
- Fibrinogen, Globulin fractionation
- Gas analysis, manometric
- Hippuric acid
- 17 — Ketosteroids

GROUP IV (15 to 20 units per procedure)

- Brom-sulphthalein — liver function
- Blood volume or circulation time tests
- Glucose, Galactose or Insulin tolerance tests
- Gastric test meals and analyses
- Hippuric acid synthesis — liver function
- Kidney function tests — PSP, Fishberg Lashmet-Newburgh
- Orthostatic albuminuria test procedure
- Urea clearance
- Special analyses of food samples (with ashing, etc.)

Comparisons have been made between these DVA Work Units and those advocated by some other agencies. A Committee of the Canadian Association of Pathologists and a Committee formed by the Directors of Provincial Public Health laboratories in Canada have been studying the unit systems advocated by the Nuffield Provincial Hospitals Trust, by the Public Health Laboratories of the Province of Ontario and by the Emergency Medical Service of Great Britain as presently modified by the Ministry of Health. Other systems such as those in use in several State Health Laboratories and the point rating method of the U.S. Army have also been examined but have not been given trials for a variety of reasons — in some cases because of poor coverage of hospital laboratory work and in others, because they are too cumbersome for routine use.

For the Veterans Hospitals, I have paid particular attention to the Nuffield Trusts' system as modified by the Ministry of Health in Great Britain because it has the temporary approval of the Dominion Bureau of Statistics and is meeting with a relatively favourable reception from the Canadian Association of Pathologists. The point scores by this system are shown in the second column of Table I (Dominion Bureau of Statistics) for comparison. Although it has not been tried in our laboratories, the system used in the Province of Ontario is also shown (Ontario Public Health) because it is based on a far wider range of values and, in effect, calls for a great deal of individual test scoring.

To-date, we have not been inclined to adopt the Nuffield system in its entirety, partly because it calls for many more individual test ratings in Haematology, Bacteriology and Biochemistry as shown by ranges in the table and partly because some of the scoring does not conform to our methods of practice. In respect to the first mentioned objection, technicians making up the scores have to accustom themselves to about 14 different scores in Biochemistry as against 5 by the DVA system, in Bacteriology 13 scores against 9, in Haematology 9 against 5. In respect to the second objection, typical examples are seen in Parasitology, in dark-field examinations in Bacteriology and in Blood Transfusion work. Most of the work in our laboratories is done by technicians (high unitage) whereas most is done by professional staff in Great Britain (low unitage).

My feelings at the present time are as follows:

1. The "Work Unit" or point scoring system is now generally accepted as being the only practical method for the comparative assessment of work loads in hospital laboratories.
2. It is not practicable to include professional services in a point scoring system.
3. No matter what system is adopted, there will always be marked differences on a measurable, technician-productivity basis between small and large laboratories. It follows that a unit purporting to represent either a measurement of time or a unit of cost offers no particular advantages over arbitrary units which are only intended to indicate proportionate complexities of work being done.
4. Unit scoring in hospital laboratories, because of the diversity of the work, usually has to be done by the technical

Please turn to page 87

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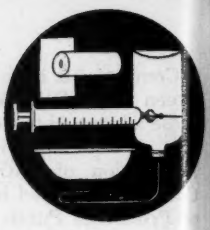


Central Service Meets in Chicago

■ MEMBERS OF THE central service section of the Tri-State Hospital Assembly were guests of HOSPITAL MANAGEMENT at a luncheon in the Morrison Hotel on May 3, 1956. This was a history-making occasion since it was the first time central service people in this area had so gathered.

Below: Charles U. Letourneau, M. D., Editorial Director of this Journal, addressed the group. At his left are Sister Cletus, Anderson, Ind., Ruth C. Harvey, Dearborn, Mich., Esther Abbott and Mrs. Eva Buckingham, of Chicago hospitals.

Speakers' table.

Guest speaker Edward D. Barry.

Left: Dr. Letourneau chats with some of his guests: Sister M. Irma, Terre Haute, Indiana, Miss Abbott, Sister Cletus and Sister Bernadilla, also from Terre Haute, Indiana.

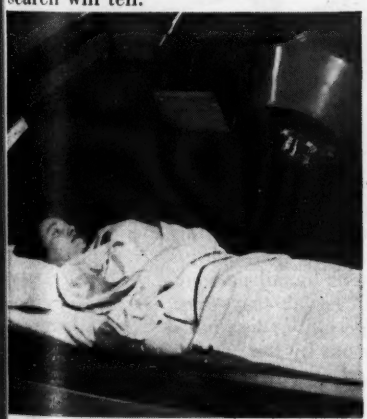
Below left: Mrs. Betsey Carroll, Kansas City; Ruth C. Harvey; Margaret K. Schafer, Battle Creek, Mich.; and Mary Helen Anderson, Central Service Editor of HM.

Above Right: Daniel F. Moravec, Pharmacy Editor of HM, was another guest, shown with Mrs. Hanna and the two sisters from Terre Haute.

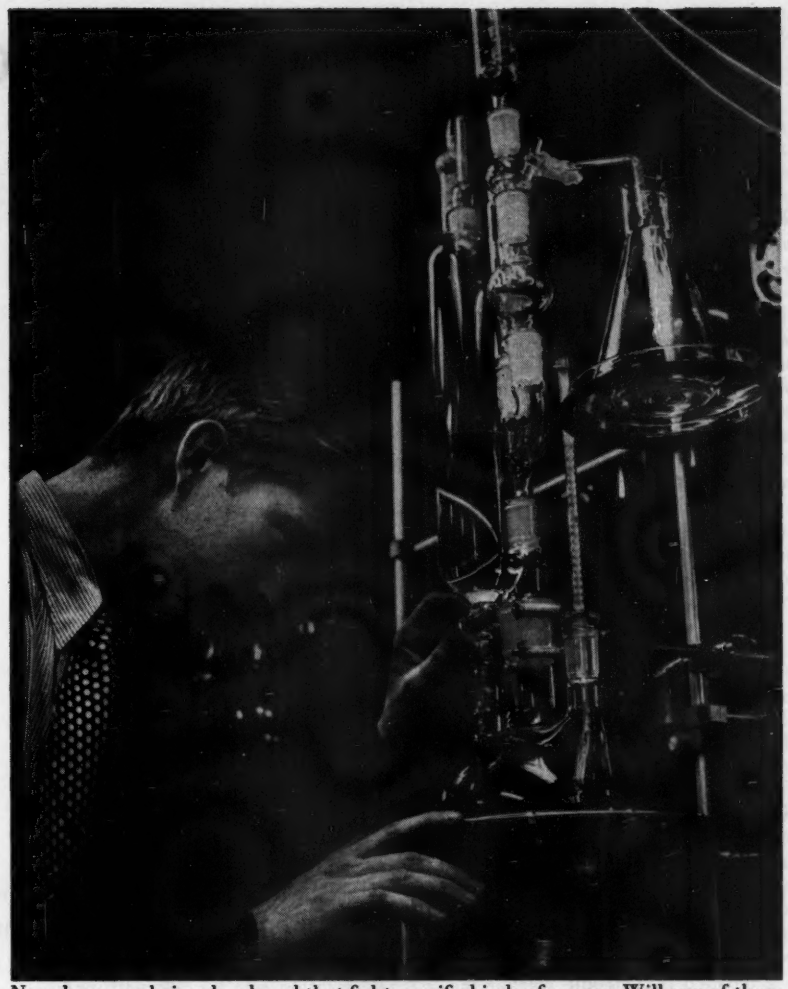
Right (l. to r.) Mrs. Mildred Delsman, Milwaukee; Betty Hanna, Associate Editor of Hospital Management and Mrs. Eva Buckingham.

Cancer and healthy cells seem to feed on different kinds of "food." We know how to make some cancer cells die by starving them. Will we starve out all kinds of cancer cells one day? Only more work and research will tell.

Some cancer patients develop substances that fight their own tumors. When science knows more about antibodies, we may have a new cancer treatment. Only more work and research will tell.



Some cancers are being halted by atomic materials. Can new radioactive isotopes affect other cancers in the same way? Only more work and research will tell.



New drugs are being developed that fight specific kinds of cancer. Will any of them turn out to be cancer-killers? Only more work and research will tell.

Some good news about cancer

. . . and how you can make the news better

These photographs illustrate some of the work our scientists are doing in the fight against cancer. Just one thing is needed to keep this research going. Your help. If you—and all of us—give today, the research will go on until we conquer our greatest enemy—cancer. Help fight cancer with your check. Give generously. Send your contribution to CANCER, c/o your town's Postmaster. AMERICAN CANCER SOCIETY.

For more information, use postcard on page 113.

How Central Service Grows

Part II

This is the second part of a two-part article. Part I appeared in the June issue.

by Eva Noles, R.N.

With the increased patient load, more syringes are used. At present more than 1000 syringes are processed daily. Each floor has one syringe pan of 24 2cc syringes and one of 24 5cc syringes which are exchanged twice daily or more as necessary. Other sizes are wrapped individually and dispensed as needed. All are exchanged on a one for one basis. In the beginning, all syringes were wrapped individually, but the loss was terrific. They were just too handy.

An automatic syringe washer solved our cleaning problem. All but the smaller sizes are rinsed in distilled water before wrapping. This reduces the chance of a possibility of an error in blood chemistry determination because of any deposit left on the syringe.

With the increased use of syringes, came the increased use of needles. These are packaged in pans of 25 each and also in the individual paper wrappers, as well as in glass constriction tubes. Nearly 2000 a day are cleaned in a needle washer machine, tested, sharpened, sorted, packaged and sterilized.

The problem of protecting the points on the needles while awaiting packaging was solved by use of a simple box-like holder 10″ x 10″ x 3″, bottomless, with copper mesh screening across the top. These were made up according to our specifications by the maintenance department. Ordinary window mesh works well for most needles. The needles are simply stuck through the mesh openings with the hubs exposed.

Bottles used for irrigations (mouth, catheter, naso-gastric) tubes are washed on an electric bottle washer. After draining, these are wrapped, labeled, dated on bottom of package, sterilized and stored by stacking them on their sides, thereby leaving the dates visible. Some 4-6 dozen bottles are processed daily.

Catheters are supplied to the entire patient area except for the urology clinic. Cellophane tubing has proven satisfactory, providing clear visibility and complete proven sterility for 1-2 months. Catheters are reused as much as possible. Upon return to Central Supply they are soaked in a disinfectant solution for 30 minutes, rinsed in tap water, drained, packaged and autoclaved for 15 minutes. A paper threader is a great help to us and to the nurses using the catheters.

Sterile tracheotomy and laryngectomy tubes are in constant demand. Two tubes are provided for each patient — one in use, one as a spare on the nursing unit. Dozens of tubes of assorted sizes are always available.

In March, 1956, a census of 288 has meant an increase in numbers and kinds of sterile trays needed. Irrigation trays for colostomy, perineal, eye and oral care are available as well as catheterization trays, enema and douche trays. The neuro-surgical department uses angiogram, encephlogram, ventriculogram, myleogram and nerve block trays. Diagnostic X-ray requests bronchogram and arteriogram trays. Modern diagnostic procedures call for Silverman needle biopsy and sternal puncture trays and more venesection, paracentesis and thorancentesis trays. Thoracic service utilizes underwater drainage sets, equalization sets for use with pneumothorax apparatus and thoracotomy sets.

Emergency demands have increased to include bronchoscopic, tracheotomy and gynecological emergency trays, airways, nebulizers, oxygen masks and catheters, plasma, dextran and suture needles and suture materials.

All dressings used are dispensed from Central Supply. All dressings are autoclaved; even those used where sterile dressings are not required. Dressing carts are provided with sterile dressings in stainless steel covered cans which are exchanged as needed on a one for one basis. These include 2″ x 2″, 4″ x 4″ and 4″ x 8″ filmated sponges. All gauze sponges are supplied on demand.

Equipment has more than doubled, so much so that more room was needed and supplied for storage. Mobile equipment includes 2 Stryker frames, 2 patient-lifts, 3 commodes, 1 nursery chair, 3 types of walkers — convalescent, Walk-O-Pedic and regular with wheels, 12 tidal irrigators, 38 electric evacuators, 18 aspiration pumps, 2 heat cradles, 1 perineal lamp, bed boards, electric fans, hot plates, shampoo trays, hair dryers, patient transfer rollers, plus orthopedic needs as splints, Bucks' extensions, Balkan frame, etc.

Floor needs are supplied through a pick-up and delivery service by Central Supply attendants twice daily. To avail themselves of this service, head nurses have to submit their requisition to Central Supply by 8:30 a.m. and 2:30 p.m. Otherwise they must send their own personnel. All used equipment and trays receive the initial cleaning on the nursing units before returned to Central Supply or it is not accepted.

One Direction Work Flow

All work flow is in one direction. Unsterile equipment is delivered through one door; sterile equipment dispensed from another door at the other end of the department. An intercom connecting the dispensing door to the supervisor's desk saves steps for all personnel.

Special trays are signed for in specially designated (by floors) books by the persons receiving them and are checked off when returned.

Control of all equipment is accomplished by the use of a Wall Kardex Panel which is installed by the supervisor's desk. All equipment is labeled and numbered. An index card is made out for each item and ruled so that the spaces

match the hospital floors and departments with the end space left for Central Supply. Each is placed in a pocket of the file in alphabetical as well as numerical order. A colored transparent signal is kept in the C.S.R. space until the item is moved. This signal is moved to the floor requesting item and returned only when it is returned. A red signal is used when any item is out for repairs. All items are checked daily by the Central Supply attendants during the afternoon rounds and the signals are moved accordingly. No item is lost for long.

There are three autoclaves in Central Supply, two large ones (24" x 36" x 48") timed for 30 minutes, one 20" cylindrical one timed for 15 minutes. One large autoclave is used by surgery for their bundles which they themselves wrap. The small one is for rubber goods only. All have automatic controls for timing plus graphs, temperature and pressure gauges. Sterilization is not timed until the temperature reaches 250 F. Should the temperature or pressure drop, the cycle is immediately repeated. Regular use of color indicators, lag thermometers and cultures are used as sterility checks. Two basket carts for each autoclave have been necessary to meet the demand for sterile supplies.

An electric oven for dry sterilization is used for instruments, glassware, needles in metal pans, vaseline and talc. One hour at 160° C is used for all but the vaseline and oils which are sterilized for 2½ hours and the talc for two hours.

Central Supply is open from 7:00 a.m. to 11:30 p.m., six days a week. Personnel consists of one head nurse, two staff nurses and eleven attendants. The staff nurse and eight attendants work from 8:00 a.m. to 4:30 p.m.; one attendant works 7:00 a.m. to 3:30 p.m.; one staff nurse and two attendants work from 3:00 to 11:30 p.m. and the head nurse works from 8:30 a.m. to 5:00 p.m. Each attendant takes her turn working the early tour of duty while the staff on 3-11:30 are permanent.

Rotation of Duties

Each attendant on the day tour is trained to do everything by monthly rotation of duties. Two attendants are assigned to syringes, two attendants to gloves, two attendants to rounds, one for needles, one for sterile room to dispense supplies, and one for relief for days off. The attendants assigned to rounds work in the general work room between such rounds. The staff nurse does all of the trays other than colostomy, perineal, douche, enema and catheterization trays and assists the head nurse in her duties.

The 3 to 11:30 staff maintains the quota of sterile needles, dressings, catheters, etc., finishes jobs that the day staff is unable to complete, cleans the sterile room and supplies items to nursing units on request. All sterile supplies are kept sterile by re-autoclaving every two weeks. Other duties include rounds which are made daily to each floor to replenish the stock of parenteral fluids used during the 24 hour period. Rounds are made again in late evening to pick up used trays, replacing when necessary. On Saturday evening, only, rounds are made to exchange used syringes and needles for Sunday's use. Other evenings, floor attendants bring their own for exchange.

In time, an 11:00 to 7:30 a.m. staff, which in addition to answering requests from the nursing units, will service all dressings carts nightly.

Additional services will be provided when more personnel is made available. Central Supply will become *Central Service* as well. Much has been accomplished in a very short time. ■

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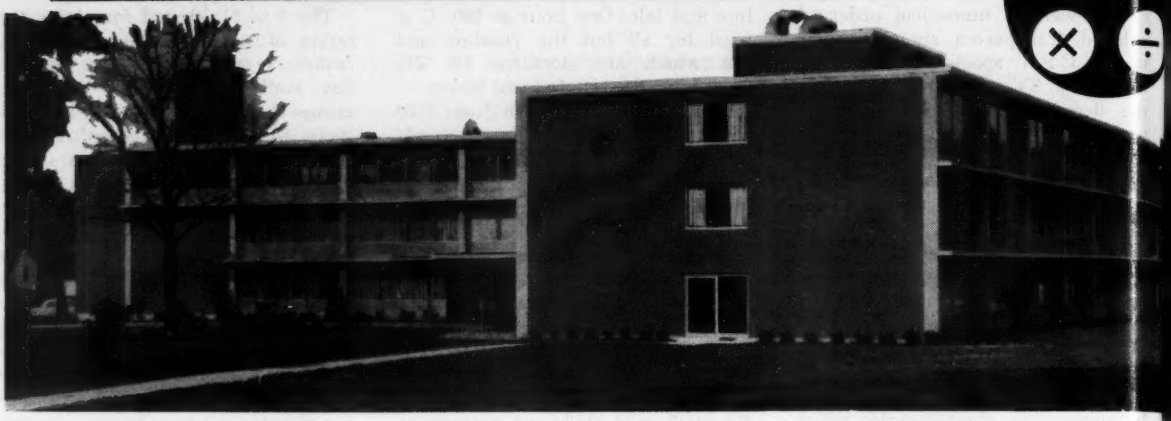


The beautiful and modern Fayette County Hospital located in Vandalia, Illinois.

A Complete Hospital Accounting System

by William A. Deems

■ HAVING HAD EXPERIENCE with various hand bookkeeping systems, we know all too well how costly such methods can be, and how difficult it is to maintain full accuracy in the important job of keeping the records straight. In our opinion, pen-and-ink accounting is justified only in the smallest hospitals.

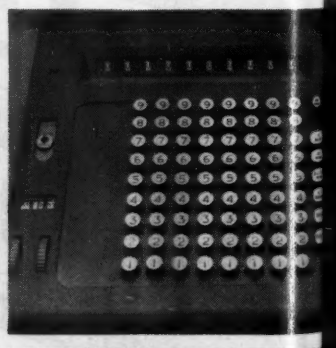
We determined, therefore, to "do the job right" from the very beginning. Fayette County Hospital started right out with a completely mechanized bookkeeping system—a system which has proved to be as nearly perfect as any director or administrator could desire. There is no question, either, of its economy. At the most conservative estimate, we would need two more employees if we were to abandon machine procedures in favor of handwritten records. This would amount to doubling the bookkeeping staff of our 103-bed hospital.

The machine system we have here is by no means something for which we take original credit. Certain phases of it are, indeed, new, but the basic plan is already used by hundreds of hospitals throughout the nation. If you are familiar with the basic plan, the section on our method of handling incoming cash may be of value.

Patients' Accounts Receivable

All charges to patients, including room charges, are written on "McBee" charge tickets. (We prefer this form because we can "needle out" the filed cards to get any kind of information needed. For instance, if we wanted to know the total charges for physical therapy to privately accommodated patients during the month of October, a simple needling operation would enable us to get the answer quickly, by run-

Mr. Deems is executive director of Fayette County Hospital in Vandalia, Illinois.

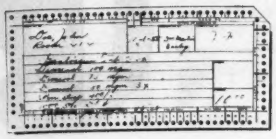


Upper left: Mr. Deems, the author, studies plans for future.

Upper right: Close-up of cashier's machine. Buttons at right cause validation of receipt, and at same time add into individual totals.

Lower left: All-purpose accounting machine processes all bookkeeping records for hospital.

Lower right: The cashier inserts the receipt in machine's "printer" as she enters the amount paid.



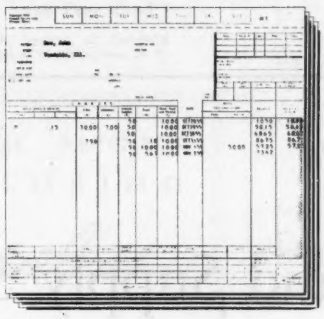


Fig. 1 (above). Patient's statement and 3 copies are printed simultaneously by machine. The information is taken directly from McBee cards (left), which are used to write up charges.

Fig. 2 (below). Totals automatically accumulated as by-product of posting patients' accounts are posted to income ledgers daily.

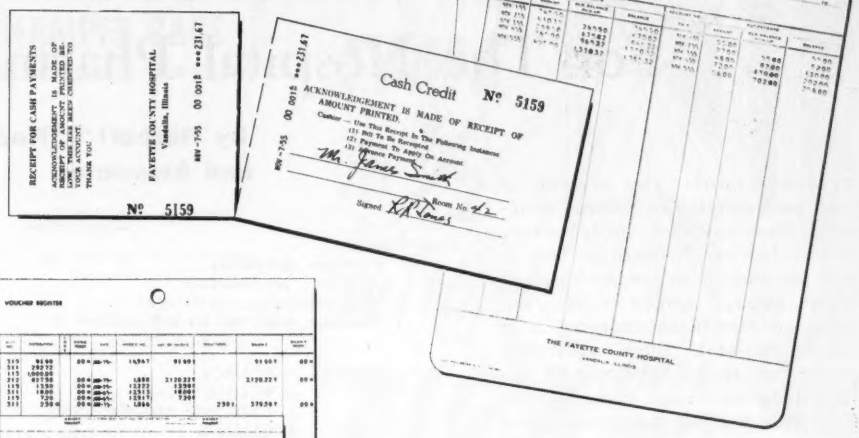


Fig. 3 (right). Two-part receipt form is "certified" by cashier's machine as amount collected adds to proper total. Copy at left is given as receipt; righthand copy is used later as posting medium.

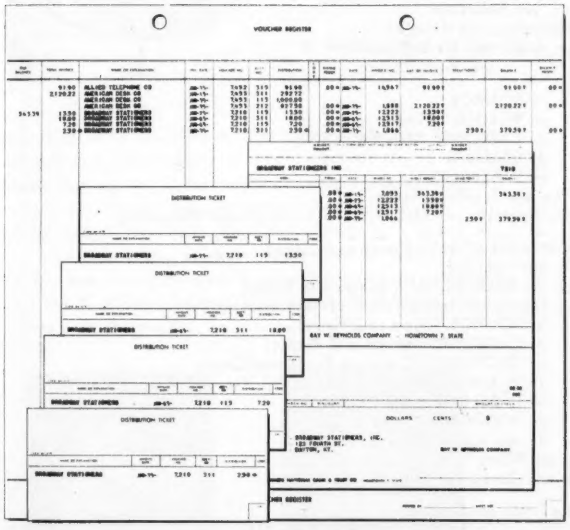


Fig. 4 (above). Accounts Payable set-up. Distribution to tickets, vouchering, preparation of remittance advice and voucher register are done at the same time. The distribution of each invoice is automatically proved against the amount vouchered.

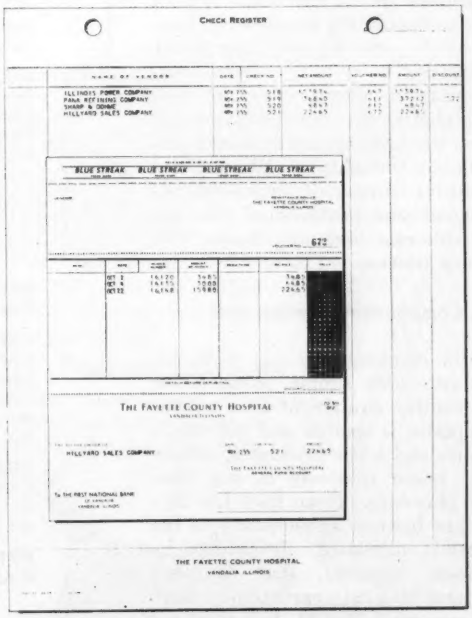


Fig. 5. (above). Check Register is produced as a by-product of writing checks, which are automatically dated and numbered by machine.

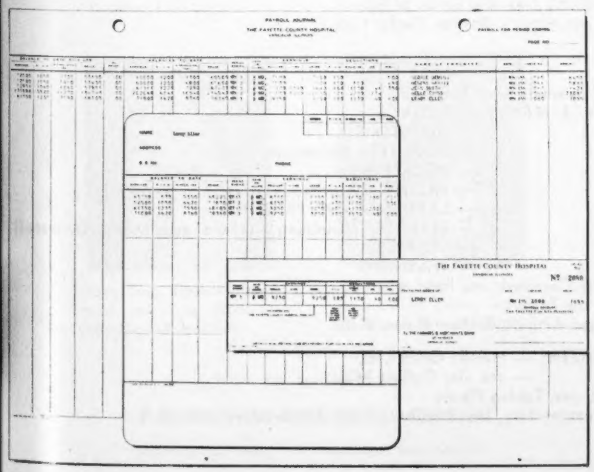


Fig. 6 (left). Mechanized payroll enables all records, including earnings record, pay statement, check, check register and payroll journal, to be finished in one writing.

Please turn to page 118

Equipment and Supply Sources For The Hospital Pharmacist

by Herbert L. Flack, M.Sc.
and Associates

■ EDITOR'S NOTE: The practice of bulk compounding in hospital pharmacy offers potential which is overlooked far too frequently. This is true particularly in smaller hospitals where general opinion is that, because of insufficient volume, it is not worth while. Such rationalism is almost always erroneous. I believe it perfectly safe to say that as long as a hospital has a registered pharmacist on its staff some type of bulk compounding practice can save money for the hospital concerned. Often the very term "bulk compounding" frightens away the hospital pharmacist and administrator. When the term is seen or heard, immediately thoughts of elaborate and expensive equipment, impossible investment, and professional time not available rear their ugly heads. This is very untrue.

Bulk Compounding Inexpensive

Bulk compounding can well begin with such simple, inexpensive, and routine equipment as a mortar and pestle, a spatula and pill tile, a balance and a few graduates; equipment found routinely in any hospital pharmacy. From here the layout can become as elaborate as the demand increases. It must be stressed, however, that in non-teaching hospitals particularly, bulk compounding should be practiced

[1]Herbert L. Flack, M.Sc. is Director of Pharmacy Service, Jefferson Medical College Hospital, Philadelphia 7, Pennsylvania. Associates in the study—Ralph S. Murphy, Jr., 2nd Lt., U.S.A.F., 3560th U.S.A.F. Hospital, Webb A.F.B., Big Spring, Texas; Ugo F. Caruso, Director of pharmacy Service, Grace-New Haven Hospital, New Haven, Connecticut. Both Lt. Murphy and Mr. Caruso were serving a Residency in Pharmacy at Jefferson when they worked on this presentation.

[2]Copies are available at $1.00 each, post paid.

Classification

Page Number

Agitators, see Mixers
Air Filters, see Filters-Air
Air Conditioning, not included
Aluminum Seals, see Flasks-Closures
see Vials-Closures

1 AMPULS — SOURCE
1 — FILLING (Piston-type)
1 — LABELING AND PRINTING
1 — SEALING
1 — WASHING
Autoclaves, see Sterilizers-Steam
Automatic Controls, see Meters-Water Conductance Measuring

2 BALANCES AND SCALES (Small and Large)
Ball Mills, not included
2 BINDING — BROCHURES (Covers and Rings)
Biological Inserts for Refrigerators, see Refrigerators
2 BOTTLES — SOURCE (Glass and Plastic)
2 — CLOSURES (Metal and Plastic)
3 — CLOSURES (Cellulose Bands and Caps)
3 — FILLING (Gravity, Pressure, and Vacuum)
3 — LABELING AND PRINTING
3 — WASHING
— see also Flasks, and Vials
Bottling, see Filling
Cabinets and Cases, see Fixtures

4 CAPSULATING MACHINES
4 CAPSULES — COUNTING AND PACKAGING
Carboy Handing, see Materials Handling
Carriers (Hand Trucks), not included
etc.
etc.

4 COLLOID MILLS (see also Roller Mills)
Containers, see Ampuls, Bottles, Flasks, Vials
etc.
etc.

5 FIXTURES (Cabinets and Casework)
5 FLASKS (I.V. & IRRIG.) — SOURCE
6 — AIR STEMS
6 — CLOSURES (Aluminum Seals)
6 — DECAPPING
6 — FILLING (Gravity, Pressure, and Vacuum)
6 — LABELING AND PRINTING
6 — SEALING (Crimping) (Hand and Motor Operated)
7 — STOPPERS
7 — WASHING
Furniture and Casework, see Fixtures
Glass-lined, see Tanks
Glassware, see Ampuls, Bottles, Flasks, Vials

7 HOMOGENIZERS — HAND OPERATED
— see also Colloid Mills
Hose-Plastic, see Tubing-Plastic
Indicators-Temperature, see Sterilizers-steam-Temperature Indicators
etc.
etc.

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HAMPER BAGS

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- No Grommets to Tear!
- No Strings or Ropes!
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To close, reach under flap and grasp the ears at corners of bag.

Pull upward and flap is sealed tightly and securely.

Turn bag upside down and carry by built-in handles at bottom.

Bag may also be used on back of chair, leaving hands free to load.

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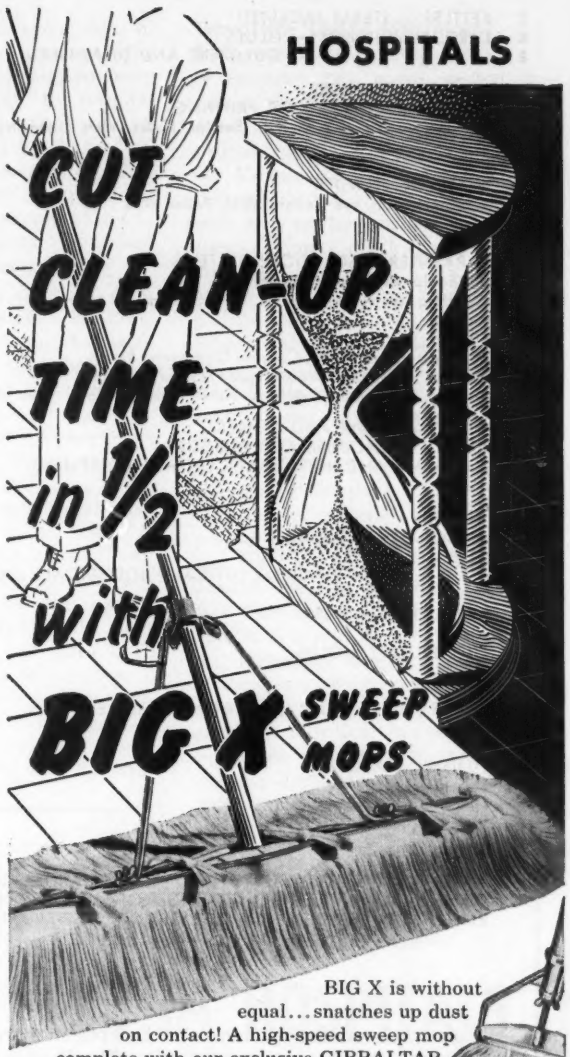

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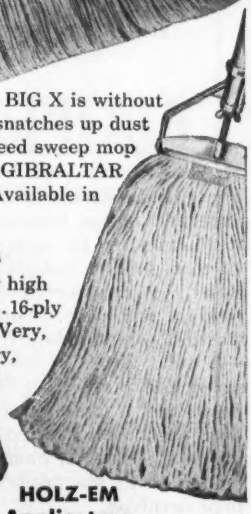

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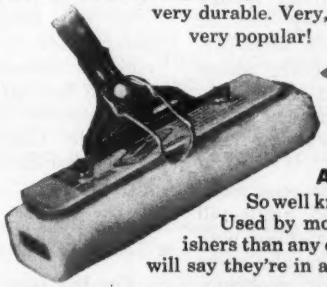

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Incorporated 1908

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7 KETTLES — STEAM JACKETED
8 LABEL MOISTENERS — GLUES
8 — GUMMERS AND DISPENSERS
8 LABELS — SOURCES
8 — MARKING OR PRINTING
8 — see also Ampuls, Bottles, Flasks, Vials (Labeling and Printing)
etc.
etc.
11 MIXERS — POWDER
Ointment Mills, see Colloid Mills, Roller Mills
etc.
etc.
11 PARAENTERAL SOLUTIONS SYSTEMS
pH Equipment, see Meters-pH
Pipetting, see Ampuls, Flasks, Vials (Filling)
etc.
etc.
Pony Mixer, see Mixers-Creams, Ointments, Pastes
Pressure Filter, see Filters-Liquid-Pressure-Vacuum
Printing, see Ampuls, Bottles, Flasks, Labels, Tubes, Vials (Labeling & Printing)
12 PUMPS — DRUM AND BARREL
12 — VACUUM AND PRESSURE
12 PURCHASE AND INVENTORY CONTROL EQUIPMENT
etc.
etc.
12 RADIOISOTOPE HANDLING
12 REFRIGERATORS — SOURCE
13 — PHARMACEUTICAL (BIOLOGICAL) INSERTS
etc.
14 STERILIZERS — GAS
etc.
15 SUPPOSITORY MOLDS
etc.
etc.
16 TANKS (MIXING AND STORAGE) — STAINLESS STEEL
etc.
etc.
17 TUBING — PLASTIC
etc.
etc.
18 VIALS — FILLING (PISTON-TYPE)
etc.
etc.
19 WATER TREATMENT SYSTEMS (DEIONIZERS, DEMINERALIZERS)
EXHIBIT A — NAMES AND ADDRESSES OF SUPPLIERS (Blue Pages)
EXHIBIT B — NAMES AND ADDRESSES OF HOSPITAL PHARMACY EQUIPMENT USERS (Pink Pages)

only on the pharmaceutical items where economy can be produced. There are instances where it is less expensive to buy than to mix and in such cases by all means buy. But, even in smaller hospitals there are usually a number of preparations used in sufficient quantity to well warrant compounding them. Money —a good deal of money—can be saved and put into beds, furniture, paint and a hundred other places over the hospital when compounding in the hospital pharmacy is exploited to fit the needs of the hospital involved.

In hospitals that have progressed beyond the mortar and pestle-pill tile stage, anyone experienced with bulk compounding will readily agree that one of the major problems, when beginning such a program, is *sources* of equipment and supply. It is the privilege of the Pharmacy Section of HOSPITAL MANAGEMENT to be able to offer to hospital pharmacists and administrators the following information taken from "Equipment And Supply Sources For The Hospital Pharmacist"[1]. This booklet was compiled by Herbert L. Flack and his associates and was presented to the Annual Meeting of The American Society of Hospital Pharmacists in Detroit (April, 1956) as another contribution to the betterment of hospital pharmacy.

In the following excerpts and paraphrases from the preface and table of contents we attempt here only to familiarize our readers with the excellent compilation that is available. Copies of this 36 page bound booklet are available from Mr. Flack.[2]

Ten Year Study

For the past ten years as one of his hobbies, the author has reviewed countless journals and has mailed requests all over the nation for information about equipment and supplies used in hospital pharmacies. As a result he has accumulated a file cabinet over-flowing with catalogs and literature. This voluminous collection of information has been drawn from many sources including hospitals throughout the country that actually use much of the equipment listed. The manuscript is completely unbiased being designed to present that which is available and where.

Also, it gives the addresses of hospital pharmacists using the equipment with the suggestion that such individuals be contacted before purchasing anything new. In other words, it provides the opportunity for prospective purchasers of equipment to communicate with present hospital pharmacist users of such equipment to obtain their opinions of any given piece of equipment. Where it is easily operated and maintained and is continually useful, the pharmacist whose hospital is listed as a user of such equipment, will naturally reply favorably to the interested purchaser. Conversely, where the equipment does not work well or serve the purpose originally presented by the manufacturer, then an adverse reply will be given and the prospective buyer can then contact other sources and users (also listed) so that the best value for the hospital's dollars spent can be realized.

This booklet is a fine beginning with future expansion intended that will make it extremely valuable to the thousands of hospital pharmacists and their administrators throughout the nation.

The above is taken from and exemplifies the "Table of Contents".

D.F.M.

American Pharmaceutical Association

Joseph B. Burt, Dean of the Nebraska University College of Pharmacy is one of the nominees for the Presidency of the American Pharmaceutical Association. I have had the distinct privilege of knowing Doctor Burt for many years and I recommend him highly.

Doctor Burt has devoted his life to American Pharmacy. He has been an ardent supporter of hospital pharmacy for a number of years. True to his usual foresight, he heads one of the comparatively few graduate courses in hospital pharmacy. He is a member of the American Society of Hospital Pharmacists and is constantly working for the progress of hospital pharmacy. No one could be more qualified and deserving for the Presidency of the American Pharmaceutical Association.

Dean Burt supports hospital pharmacy tooth and nail so why shouldn't hospital pharmacists be as loyal to him.

D.F.M.

STARKEY

Continued from page 77

staff who are the only ones capable of placing much of the work into the proper categories. It follows that the choice of a system should be heavily influenced in favour of one of minimal complexity if valuable technicians' time is to be used with due economy.

5. A composite record of work units does not, of itself, give sufficient information for judging the total work or the character of the work being done. If this is needed, it is necessary to have records kept in categories designed to show these. Thus, in Haematology — as shown in the table — hospitals doing large numbers of "routine" blood counts can be seen and similarly disproportions between different categories in Biochemistry or in Bacteriology will be apparent.

6. Work units based on technical work happen to conform to most of the needs of cost accounting in that the work unit costs parallel the relative "efficiencies" of different sizes of laboratories in inverse ratio. This useful correlation may well only apply to hospital laboratories because salaries usually account for 65 to 75% of the total cost and other large items such as equipment and expensive supplies tend to parallel the complexity index of the work being done.

These observations are backed by twelve years of experience. We hope that they may be useful to some who are considering the advantages and disadvantages of a variety of methods. ■

HUFFMAN

Continued from page 68

where the parents have equal custody the father usually signs, if available, although the mother may sign. However, if the parents are separated or divorced the parent having legal custody should sign the authorization. Your state laws should be checked in this matter.

There is an excellent discussion regarding this subject on page 259 of Hayt, Hayt and Groeschel's *Law of Hospital, Physician and Patient.* ■

Governor Lauds Pharmacy Industry

■ PRAISING THE RAPID, recent increase in voluntary health insurance to a total of more than 100 million persons, Governor Robert B. Meyner of New Jersey today pointed to 60 million Americans still not protected and called for their complete medical and hospital coverage.

Meyner paid tribute to the "vision of leadership in the pharmaceutical, drug, chemical and allied industries in organizing the Health Information Foundation which", he said, "is pointing the way towards defraying the family health bill.

"The businessmen heading participating companies realize the necessity of making available to the public feasible plans which people can afford for their protection against the cost of illness. Through HIF they sponsor studies to develop data that would be necessary before any insurance company could safely contemplate a far-reaching extension of existing types of health insurance and new types of health insurance necessary to meet present-day demands. In brief, pertinent actuarial data is necessary." ■

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THE GIVE AND TAKE IN HOSPITALS

A STUDY OF HUMAN ORGANIZATION

By Temple Burling, M.D., Edith Lentz, Ph.D., and Robert Wilson, Ph.D.

Foreword by GEORGE EUGBEE

Discussing many problems which confront hospital administrators and supervisory personnel, the authors bring to their subject a broad range of information. They deal with facts assembled by a research team of the Cornell University School of Industrial and Labor Relations working with the American Hospital Association and a group of representative hospitals.

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Tailor-Made Recipes

How to: Streamline production
Cut costs
Standardize recipes

by Pearl Aldrich

■ STANDARDIZED RECIPES can be sharp tools for streamlining production and cutting costs. Every recipe must fit the special requirements of *your* food service. A tailor-made recipe fits the specific needs of a particular food service for (a) quality, (b) portion size, (c) total yield, and (d) raw food cost.

Check carefully what needs to be done to adapt every recipe to *your* needs. Does the original recipe have the exact yield desired, directions for panning and portioning to fit *your* equipment, and clear, complete directions?

A tailor-made standardized recipe must pass the following tests:

(a) A well arranged, uncluttered format with enough blank space for easy reading
(b) Neat columns for ingredients
(c) Limited number of yield columns
(d) Brevity and clarity of directions
(e) Careful word choice
(f) Natural and orderly arrangement of ingredients
(g) All necessary information about yield, pan size, baking time and temperature, and cutting and serving instructions

In Figure 1, the sample recipe illustrates these basic points.

Let us look at the essential steps in successfully tailoring a recipe from a reliable source to fit your own needs.

Format

Give careful thought to the format—its size for easy handling and filing and its arrangement for quick reading. Small cards with elite type or fine print, crowded columns, and too brief directions may ruin the chances of enjoying the many advantages of standardized recipes. Count the number of "squinters" and bifocals in the kitchen before you decide on the format for your recipes.

Visualize the recipe in use in a working situation. We sometimes forget that recipes must be in a form easily read by a worker moving about quickly. Both good recipes and good workers are frequently blamed for product failure, when the failure might more logically be attributed to a hard-to-read format.

Allot specific space for panning and portion instructions, cooking temperature and time, and pan sizes. Place the same kind of information in the same relative position on every recipe.

Use horizontal shadow lines between ingredients on a recipe to help the busy cook. If you've ever read down an extra line or over an extra column in an attempt to balance a ledger, you know that such things happen.

Keep the format uncluttered. Allow the essential information to stand out in a field of white or plain color. Crowded columns for listing amounts of ingredients or too many columns for different yields on a single card contribute to product failures. Like an effective window display or a good advertisement, a good format for a recipe depends on an uncluttered background for emphasis of important things.

If your food service requires more than one yield for certain items, use two or three columns for listing amounts of ingredients. However, more than three columns may result in confusion and mistakes. If your production requires more than three different yields, use two or more cards for the same recipe instead of attempting to put too much on a single copy.

Instructions

Make directions brief—but clear. Your production people today may be experienced and able to read between the lines, but the day may come when you will have inexperienced workers who will need to follow instructions to the letter. Make directions complete and meaningful.

Be careful about word choice. If you mean "whip," or "fold," or "beat," say so. Don't simply say "mix" and expect the cook to figure out the best technique.

Give some thought to listing ingredients in the sequence in which they will be used in the recipe. The practice of grouping ingredients which are to be added as a unit is also helpful to the worker.

Block directions across from the ingredients concerned so that the work progresses easily and quickly.

Adapt the yield so that it will give *exactly* the number of portions you desire and the size portions you need to keep your customers happy and your food cost in line (Fig. 2). Over-yield recipes cost you profit every time you serve them.

Data to Include

Be sure to include the *name* of the item in a conspicuous place. Include a code file number for setting up a cost notebook or for identifying products on the back side of counter signs if you wish.

Determine the portion size. We learned some startling things about portion sizes of cakes in a recipe

Miss Aldrich is head of the food service laboratory and associate professor of home economics at Michigan State College in East Lansing, Michigan.

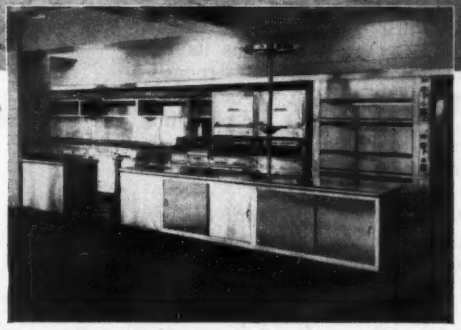
back-to-back counters save equipment and labor

AT ST. VINCENT'S HOSPITAL, WORCESTER, MASS.

ideas from Blickman-Built food service installations

SAVINGS IN EQUIPMENT AND LABOR result from the back-to-back arrangement of cafeteria counters. Both are served by a common back-bar and food storage facilities. One cashier handles both lines. Personnel can be reduced during "slack" periods, since one attendant can operate similar stations at both counters. Stainless steel construction aids sanitation.

• This installation at St. Vincent's Hospital shows how to plan for economy without sacrificing efficiency. In the cafeteria, two stainless steel counters are arranged back-to-back so that each shares the same back-bar and food storage facilities. Equipment costs are kept to a minimum . . . service fully meets the needs of the institution. In the main kitchen, economies are also obtained through use of Blickman-Built equipment which permits orderly, convenient food preparation and low-cost sanitary maintenance. Let us show you how "Blickman-Built" can mean virtual built-in efficiency and economy for your food service installation.



BUILT-IN EFFICIENCY is reflected in the equipment for the cooking section. The stainless steel cook's table, close to ranges and ovens, has built-in warmers, built-in bain marie and pot rack. Crevice-free work surfaces simplify cleaning. Raised tile bases also aid sanitation by eliminating hard-to-clean inaccessible areas.

This illustrated folder gives more information about Blickman-Built food service installations. Send for your free copy today.

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MASS FEEDING EQUIPMENT

For Service Life Measured In Decades

S. BLICKMAN, INC., 1607 GREGORY AVENUE, WEEHAWKEN, N. J.

For more information, use postcard on page 113.

From top:

Fig. 1. Sample of standardized recipe, tailor-made for given situation.

Fig. 2. Standardized recipe tailored to meet specific yield requirements.

Fig. 3. Variation in portion sizes results from lack of portion control.

workshop last summer. All ten participants *thought* they knew the size portions they had been serving. Analyzing their own recipes in the light of their panning and cutting practices, they found that portions actually varied from 1.3 to 3.0 ounces. We then cut from sheet and layer cakes the size portions our checking showed that they had been serving (Fig. 3). These facts were pretty hard to believe—especially when all ten had been reasonably sure they were doing about the same thing!

Reproducing Copies of Recipes

Consider the methods of reproducing multiple copies of recipes for a master file or working files. Printing is expensive for a food service requiring only a few copies of each recipe. The typewriter has its well known limitations: it is expensive from the standpoint of labor both for typing and for proofreading. Careless proofreading can be the source of many expensive errors and product failures.

Ozalid process is a relatively new method of producing multiple copies. A master copy is typed with a carbon ribbon on specially treated paper from which any number of copies may be produced at any time. Only the master copy requires proofreading. It costs only a few cents more than a regularly typed recipe, and processed copies cost from 2 to 5 cents each, a minimal expenditure per copy. You can really preserve the results of the effort which goes into tailoring a recipe to do exactly the job you want done. Many photographic studios offer this service, and small equipment to do the job is also available for about $500 for those who might need to make multiple copies of many different things, and thus justify such equipment.

Summary

Standardized recipes are fine—as far as they go. But reputations for

RECIPE FOR A TAILORED RECIPE
1- ESSENTIAL INFORMATION
2- BRIEF. CLEAR DIRECTIONS
3- NEAT COLUMNS- UNCLUTTERED FORMAT

12 X 22 X 2" PANS
CUT- 48

GINGERBREAD

350° F. OVEN
40 TO 45 MIN.

INGREDIENTS	NO. OF PANS 1	2	3	PROCEDURE
HYDROGENATED FAT	9½oz			CREAM TOGETHER 10 MINUTES, PADDLE ON MEDIUM SPEED.
SUGAR	9½oz			
EGGS	6½oz			ADD GRADUALLY, BEAT TILL FLUFFY.
BAKING MOLASSES	1 lb 13oz			ADD SLOWLY, BEAT TILL FLUFFY.
CAKE FLOUR	1 lb 8oz			SIFT TOGETHER.
CINNAMON	2⅓t			ADD ALTERNATELY WITH WATER. BEAT 2 MIN. MEDIUM SPEED. SCRAPE DOWN AND BEAT TILL SMOOTH.
CLOVES	2⅓t			
GINGER	2⅓t			
SALT	2½t			
SODA	¾oz			
HOT WATER	2½c			
BATTER WEIGHT	6 lb			SCALE BATTER INTO GREASED PANS, 6 lb PER PAN, FOR BAKING.
COST PER PAN (less)	.9038			

Fig. 1

IT'S HIGH TIME
TO CHECK PORTION SIZE
TO CONTROL R.F.C. IN PRODUCTION
MAKE EACH PORTION PAY IT'S OWN WAY

12 X 22 X 2" PAN
CUT-48- (6 X 8)

GINGERBREAD

PORTION: 2 OUNCES
2 X 2¾" PIECE

INGREDIENTS	OLD LB.	OZ.	T	COST	ADJUSTED LB.	OZ.	t.	COST	PROCEDURE
FAT		12				9½			REDUCTION FACTOR 7.75 ¢ / 6.0 = .8
SUGAR		12				9½			
MOLASSES	2	4			1	13			1. EACH FACTOR IS MULTIPLIED BY .8, e.g. 12 oz. X .8 = 9.6 oz.
FLOUR	1	14			1	8			
CINNAMON			1				2¼		9.6 oz. FOR WEIGHING WITH MOST KITCHEN SCALES MUST BE CONVERTED TO NEAREST ½ oz. OR, IN THIS CASE, 9½ oz.
CLOVES			1				2¼		
GINGER			1				2¼		
SALT			1				2¼		
SODA						¾			2. REDUCE EACH INGREDIENT IN LIKE MANNER.
HOT WATER	1	8			1	3			
EGG		9½				6½			3. ADD NEW BATTER WEIGHT FOR DOUBLE CHECK.
BATTER WEIGHT / PAN	7	12½		$1.1440	6	2		$.9038	
2 oz. PORTION COST				.0236				.0188	

Fig. 2

LOOK !!
YOU CAN HAVE YOUR CAKE AND PROFIT, TOO !

PAN 6" PORTIONS FROM 12X22X2" SHEET CAKE

WEIGHT CUT	1.33 oz.	1.6 oz.	1.92 oz.	2 oz.	2.5 oz.	3.02 oz.
PORTIONS	72	60	50	48	40	32
DIMENSIONS	2⅞ x 1⅞"	2⅞ x 2⅛"	2⅞ x 2⅛"	2⅞ x 2⅛"	3⅛ x 2⅛"	3⅛ x 2⅞"

PORTIONS FROM 2-LAYER CAKES

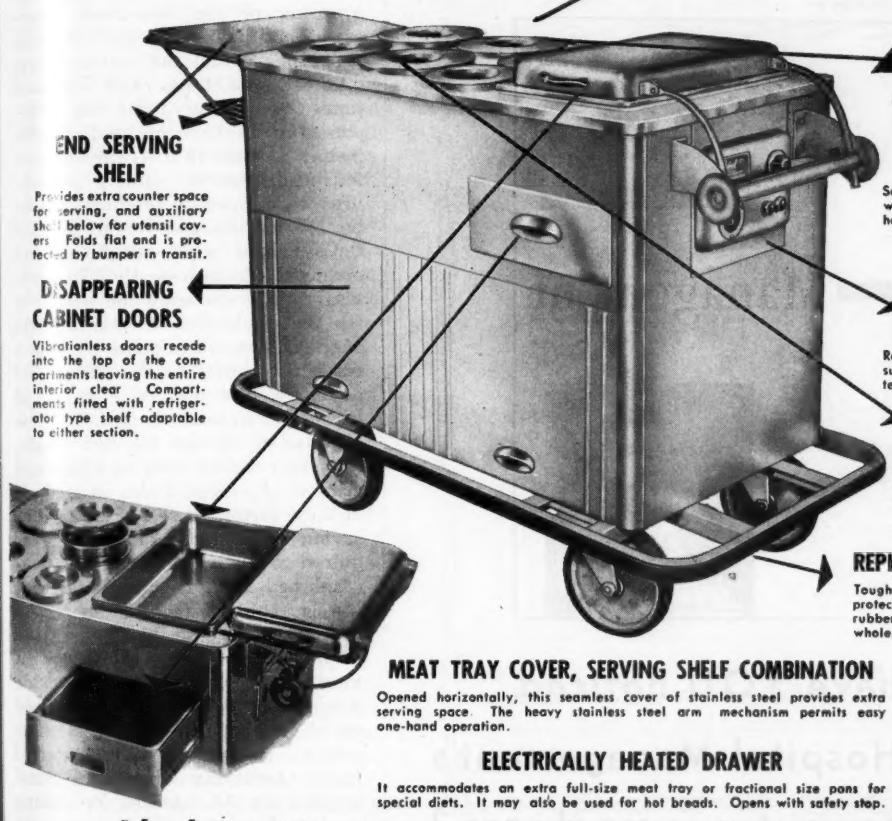
DIAMETER	8"	8½"	9"	9"	9½"	10"
PORTIONS	16	16	16	14	16	16
WEIGHT CUT	2.75 oz.	1.75 oz.	1.75 oz.	2.5 oz.	2 oz.	2 oz.
WEIGHT LAYER	1 lb 6 oz.	14 oz.	14 oz.	1 lb 2 oz.	1 lb	1 lb

Fig. 3

IDEAL FEATURES make your food service EASIER...

BRIDGE TYPE CONSTRUCTION

This exclusive construction permits the weight of food and utensils to be carried through the frame to rest on the chassis. The 20-gauge stainless steel top deck cannot sag, and can carry considerable extra weight without damage. Only Ideal gives such extra strength, plus lifetime durability.



END SERVING SHELF

Provides extra counter space for serving, and auxiliary shelf below for utensil covers. Folds flat and is protected by bumper in transit.

DISAPPEARING CABINET DOORS

Vibrationless doors recede into the top of the compartments leaving the entire interior clear. Compartments fitted with refrigerator type shelf adaptable to either section.

INSULATED COVERS

Seamless plug covers are fully insulated with fiber-glas to insure minimum heat loss.

AUTOMATIC TEMPERATURE SELECTOR

Robertshaw Automatic Thermostat assures foods at original hot serving temperatures.

SEAMLESS UTENSILS AND WELLS

Round utensils, meat trays and wells are seamless 20-gauge stainless steel. Large rims on utensils for easy lifting and offset shoulders for perfect cover seal.

REPLACEABLE BUMPER GUARD

Tough aluminum bumper assembly fully protects body of conveyor. Clincher type rubber bumper guard easily replaced, in whole or part.

MEAT TRAY COVER, SERVING SHELF COMBINATION

Opened horizontally, this seamless cover of stainless steel provides extra serving space. The heavy stainless steel arm mechanism permits easy one-hand operation.

ELECTRICALLY HEATED DRAWER

It accommodates an extra full-size meat tray or fractional size pans for special diets. It may also be used for hot breads. Opens with safety stop.

*Shown above is Ideal Food Conveyor Model 1431, capacity 60 to 120 meals. Other models available with capacities from 20 to 500 meals.

Ideal hospital equipment, made only by Swartzbaugh, is specially designed—inside and outside—to fit your need for maximum efficiency, fingertip convenience and lasting utility. That's why Ideal equipment items—food conveyors, tray conveyors, sterilizers and therapeutic equipment—are found in leading hospitals everywhere.

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MURFREESBORO, TENN.

For more information, use postcard on page 113.

excellent food are built on attention to "little things"—and most important among these is the tailoring of every recipe to do the specific job you want done in *your* particular food service. Tailor-made recipes will help you to know where you are going—not just where you have been—in quality control, portion and yield control, and cost control. ■

SMALLEY

Continued from page 62

report that the average motor is not a sealed unit but it is totally enclosed, that it can be explosion-proofed, and that it is in its present position for sound reasons. The manufacturers feel that it is not economically feasible to have the elevating motor raise and lower the back rest or knee rest, that the elevating speed was determined by methods other than scientific, that power sources other than manual and electrical are not yet developed, and that leveling the position of the two-crank bed is difficult. They report a wide variation in physical dimensions of beds and springs and in costs, and point out that some gatch springs are interchangeable and some are not.

Work Measurements

One of the criteria for judging the relative merits of the variable height feature of the hospital bed is the work content of the motion sequences required in raising and lowering the bed and the work content of the motion sequences in carrying out common nursing procedures. Conventional stop watch time studies were made on the raising and lowering of the two-crank, one-crank, and powered beds. Statistical properties, actual and normal times, total allowed times and standard times were secured for the component work elements and for the task as a whole (Fig. 4). In addition, fourteen common nursing procedures were timed by the nurse member of the research team. Median time values were computed and arranged chronologically. The advisability of changing the height of the bed would seem to be a function of the time saved in doing work at a convenient height, the time and effort saved in getting in or out of bed at a convenient height, the time required to change the bed height, and other factors such as safety and comfort of patient. From an analysis of these factors, it seems that a time saving in excess of 1.75 minute is required to justify changing the two-crank bed, and a saving of 0.40 minute is required for the one-crank bed. The powered bed presents a complication due to the fact that there is an opportunity to provide productive work internal to the fixed cycle. The tentative critical time values (minimum time interval limits justifying change in bed height) are 8.8 minutes for raising *or* lowering and 17.5 minutes for raising *and* lowering the two-crank bed. Among the common nursing procedures qualifying under these restrictions with regard to raising *or* lowering are making an occupied bed, preparing patient for dissolving gallstones, giving pre-breakfast care, and giving A.M. care. The only procedure of the fourteen studied which qualifies under these restrictions for raising *and* lowering is giving complete bed bath. Corresponding critical time values for the one-crank bed are 2.0 and 4.0 minutes. Obviously, a great number of nursing procedures will qualify under these restrictions for the one-crank bed since a mere saving of 0.20 minute is required (Fig. 5).

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Engineering Economy

In order to determine the engineering economy of bed types, cost information was secured from several sources. An analysis of these costs shows that daily savings of $.05, $.13, and $.40 are required to amortize in one year the added cost of the two-crank, one-crank, and powered beds, respectively. A further analysis shows that the one-crank bed is a better investment than either the two-crank bed or the powered bed based upon monetary costs alone (Fig. 6).

Patient Safety

One of the factors affecting the relative merits of various bed heights is the severity of injuries resulting from falls. A kinematical analysis shows that the impact at a 33.8 inch height is 62.4 lb-sec. and at a 18.3 inch height the impact is 46.1 lb-sec. There are many variables affecting severity of injury in addition to bed height, but other things being equal, a patient will be more seriously injured in a fall from a high position. From this analysis, the patient will reach the floor from a height of 33.8 inches with an impact 35.4% greater than would be the case from a height of 18.3 inches.

Conclusions

The general objective of the hospital bed project appears to be an objective worthy of further pursuit. A long-range, comprehensive study along the lines outlined in this report holds promise of yielding valuable results. This pilot study has demonstrated that the projects motives are noble, that there are problem areas requiring scientific study, that the gaps in our knowledge are retarding progress, and that significant results are attainable.

The pilot study has provided experience which will be of assistance in further inquiries. It has developed certain methodologies, it has tentatively answered certain questions and has uncovered and posed other questions, it has broadened the scope of the project as a whole, and it has served as a stimulus and a challenge to those participating in it.

In general, the pilot study indicates that some type of variable-height bed is necessary for the attainment of a workplace which permits easy, quick, minimal-fatiguing, economical work motion patterns by the health team and for the attainment of a resting place which permits safe, comfortable, economical body mechanics by the patient in getting in and out of bed. A compromise fixed-height bed is likely to incorporate the undesirable characteristics of both the high and the low heights. From wholly a cost point of view, the one-crank bed is more economical than either the two-crank or the powered bed, assuming that savings in nurse time can be translated into dollar savings. Considering patient and nurse convenience, factors tend to favor the powered bed. The time interval required to perform a nursing procedure determines the feasibility of changing the bed height.

Of paramount importance is the inescapable conclusion that there has been little or no standardization of the elements comprising the patient unit. The multitude of differing features and characteristics of contemporary variable-height beds cannot be equally good or bad. Standardization based upon simplification conceivably can discover some combination of features which will result in a manifestly superior bed, bed unit and patient unit. Toward this end, investigators are invited and urged to strive. ■

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Monthly Menus

	Sunday	Monday	Tuesday
Breakfast	1 Red plums Hot or ready to eat cereal Scrambled eggs with ham Toast	2 Blended fruit juice Hot or ready to eat cereal Bacon curls Pecan coffee cake	3 Tomato juice Hot or ready to eat cereal 3 minute egg Toast sticks
Lunch	Broiled chicken Fluffy rice Candied squash Melon ball and cherry salad Peach ice cream sundae	Roast leg of veal Watercress potatoes Harvard beets Shredded lettuce with Fr. dressing Pineapple upside down cake	Grilled ham slices - raisin sc. Sweep potato surprise Fresh asparagus Rosy apple salad Chocolate chip pudding
Dinner	Vegetable soup Welsh rarebit on crackers Baby green lima beans Perfection salad Fresh pear	Split pea soup Cold luncheon meats Imperial macaroni Citrus fruit salad Butterscotch blanc mange	Chicken rice soup Jellied veal loaf Creamed peas Tiny poppyseed rolls Fresh applesauce
Breakfast	8 Honeydew melon Hot or ready to eat cereal Link sausage Raisin bran muffin	9 Bananas in cream Hot or ready to eat cereal Scrambled eggs Toast	10 Baked rhubarb Hot or ready to eat cereal Shirred egg Toast
Lunch	Breaded veal chop Creamed potatoes with chives Corn on the cob Cinnamon pear salad Chocolate ice cream	Individual ham loaves Mashed potatoes Pimiento cauliflower Baby beet salad Baked apples with mince meat	Pan broiled liver and bacon Franconia potatoes Julienne green beans Bing cherry walnut salad Pompadour pudding
Dinner	Alphabet soup Stuffed devilled eggs Buttered broccoli Kidney bean salad Sliced peaches in cream	Cream of mushroom soup Assorted cheese platter Stuffed baked potato Tomato romaine salad Purple plum whip	Corn chowder Porcupine beef balls Broccoli Tossed citrus fruit salad Refrigerator cheese cake
Breakfast	15 Fresh berries Hot or ready to eat cereal Bacon curls Danish coffee ring	16 Grapefruit half Hot or ready to eat cereal 3 minute egg Toast croutons	17 Green gage plums Hot or ready to eat cereal Scrambled egg Toast
Lunch	Turkey with savory stuffing Whipped potatoes Brussels sprouts Vegetable relish salad Strawberry ice cream	Minted fillet of lamb Duchess potatoes Garden peas Fruit salad Pompadour pudding	Veal paprika Potato balls Buttered zucchini Corn relish salad Raisin puff with nutmeg sauce
Dinner	Lentil soup Cold roast beef Macaroni au gratin Tomato petal salad Hawaiian shortcake with whipped cream	Vegetable beef soup Turkey salad on toasted rolls Potato chips Celery and carrot sticks Fresh fruit cup	Beef bouillon Swiss cheese on rye bread Savory green beans Macaroni salad Whole peeled apricots
Breakfast	22 Canteloupe Hot or ready to eat cereal Frizzled ham Brioche - Jelly	23 Tangerine juice Hot or ready to eat cereal Baked egg Toast	24 Stewed rhubarb with orange Hot or ready to eat cereal 3 minute egg Toast
Lunch	Chicken fricassee Mashed potatoes Whole kernel corn Pickled peach salad Butter pecan ice cream	Baked ham Candied sweet potatoes Buttered wax beans Carrot raisin salad Cherry pan dowdy	Grilled sweetbreads Escalloped potatoes Creole eggplant Perfection salad Pineapple strawberry cup
Dinner	Beef bouillon Spaghetti Italienne with meat sauce Crusty rolls Combination vegetable salad Melon ball dessert	Black bean soup Chicken turnover with vegetables Cinnamon apple salad Floating island	Alphabet soup Ham cornbread shortcake Wax beans Citrus pinwheel salad Angel pudding with wh. cream
Breakfast	29 Tangerine juice Hot or ready to eat cereal Link sausages Sweet rolls	30 Green gage plums Hot or ready to eat cereal 3 minute egg Raisin toast	31 Apple juice Hot or ready to eat cereal Shirred egg Toast
Lunch	Country style steak Whipped potatoes Buttered zucchini Grapefruit avocado salad Peach ice cream	Liver loaf with spanish sauce New potatoes in jackets Swiss chard Fig orange salad Fruit meringue	Cushion roast of lamb Buttered crumb potatoes Minted peas Tossed salad greens Bananas in jello
Dinner	Chicken rice soup Cold veal in tomato aspic Baked Idaho potato Frozen mixed vegetables Boston brown bread Peppermint stick tapioca	Potato ribble soup Hamburg on bun Chef's salad bowl Assorted grape cup	Cream of mushroom soup Cold chicken slices Baked potato Hot slaw Apricot upside down cake

...July 1956

Wednesday	Thursday	Friday	Saturday
4 Orange slices Hot or ready to eat cereal Poached egg Toast ● Cubed steak with mushrooms Mashed potatoes Frozen mixed vegetables Molded cranberry salad Frog center ice cream Star sugar cookies ● Bouillion Noodle ring with creamed ham Broccoli Pickled beet salad Frosted fruit cup	**5** Grapefruit half Hot or ready to eat cereal Canadian bacon Toast ● Barbecued short ribs of beef Baked potato Braised celery Pear cream cheese salad Rhubarb tart ● Potato chowder Club sandwich Diced creamed carrots Red cabbage salad Rainbow gelatine - marshmallow sc.	**6** Prunicot Hot or ready to eat cereal Baked egg Raisin toast ● Baked codfish - lemon slice New potatoes in jackets Escalloped tomatoes Wilted spinach salad Lemon pineapple custard ● Asparagus pimiento soup Tuna noodle bake Sweet sour green beans Banana nut salad Golden cup cake - fudge frosting	**7** Grape juice Hot or ready to eat cereal Oven french toast Syrup ● Hearty beef stew with vegetables French fried eggplant Stuffed celery salad Fresh apricots ● Cream of pea soup Devilled ham and cheese sandwich Escalloped potatoes Orange apple pinwheel salad Raspberry sponge
11 Prune juice Hot or ready to eat cereal Crisp bacon Swedish rolls ● Roast shoulder of lamb Browned potato balls Swiss chard Tomato slices on watercress Orange sherbet ● Scotch broth Bread cheese souffle Peas and carrots Molded cranberry apple salad Sugar cakes	**12** Citrus fruit cup Hot or ready to eat cereal Shirred egg Toast ● Swiss steak Parslied buttered potatoes Peas and mushrooms Fresh fruit salad Marshmallow date roll ● Consomme Broiled canadian bacon Hominy cakes Tossed salad greens Melon cup	**13** Pear nectar Hot or ready to eat cereal Cornmeal griddle cakes Syrup ● Fillet of pike - tartar sauce Paprika potatoes Fresh lima beans Lettuce wedge - T.I.D. Cherry royale ● Cream of spinach soup California fruit platter with cottage cheese Spiced Harvard beets Devilsfood cake	**14** Orange juice Hot or ready to eat cereal Omelet Toast ● Pot roast of beef Steamed potatoes Wax beans and bacon Cabbage pepper slaw Boysenberry cobbler ● Alphabet soup Escalloped ham and potatoes Tiny whole carrots Lime crisp salad Banana custard
18 Fruit nectar Hot or ready to eat cereal Baked eggs Toast ● Chicken with parsley dumplings Fluffy rice Brussels sprouts Cherry nut salad Pineapple sherbet ● Cream of tomato soup Spiced tongue with cider sauce Baked potato Grapefruit avocado salad Boston cream pie	**19** Applesauce Hot or ready to eat cereal Smoked sausage Blueberry muffin ● Roast sirloin of beef Golden brown potatoes Creole eggplant Asparagus bundle salad Peach tapioca ● Hearty barley soup Frizzled beef on toast - grated egg yolk garnish Green bean and celery salad Rhubarb betty	**20** Cherry juice Hot or ready to eat cereal French toast Marmalade ● Lake trout with egg sauce Paprika potatoes Julienne carrots Chinese cabbage salad Fruit cocktail ● Split pea puree Sardines on toast Shoestring potatoes Crispy relishes Cake top lemon pudding	**21** Sliced oranges Hot or ready to eat cereal Poached egg Toast ● Meat loaf Pittsburgh potatoes Harvard beets Tossed salad greens Cottage pudding ● Noodle soup Stuffed baked tomatoes Nut bread sandwiches Fresh fruit plate Layered gelatine
25 Purple plums Hot or ready to eat cereal Crisp bacon Orange coffee cake ● Boiled beef with horseradish sauce Steamed potatoes 7 minute cabbage Apricot cottage cheese salad Raspberry sherbet ● Cream of corn soup Corned beef patties Fordhook limas Waldorf date salad Baked custard	**26** Bananas in cream Hot or ready to eat cereal Scrambled eggs Toast ● Mock chicken legs Roast potato balls Buttered summer squash Pickled beet salad Watermelon slices ● Pepper pot soup Shepherds pie Fresh green beans Pickles - radish roses Angelfood cake with strawberries	**27** Grapefruit - orange cup Hot or ready to eat cereal Omelet Toast ● Fillet of sole Cottage potatoes Spinach a la Swiss Golden glow salad Raisin rice pudding ● Clam chowder Seafood salad Baked tomato Hot biscuits - jelly Pear halves	**28** Apricot nectar Hot or ready to eat cereal French toast Marmalade ● Roast veal Potato puff Succotash Waldorf salad Pineapple cream with crunch topping ● Vegetable beef soup Assorted luncheon meats Hot potato salad Vegetable jack straws Cherry tart

Plentiful Foods MONTHLY LIST

Ice Cream
Broilers and Fryers
Turkeys
Canned Tuna in Oil

Fresh Plums
Milk and Other Dairy Products
Fresh and Processed Lemons

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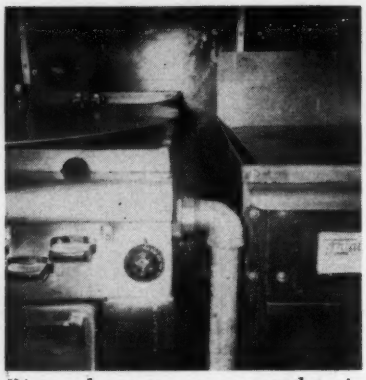
Canned Cranberry Sauce
Peanut Butter
Dried Beans

Steam Cleaning Kitchen Equipment

by Otto F. Manthei



Dirt and grease can accumulate in hard-to-reach places, between stoves.

Canvas around stoves protects other parts of kitchen, cuts down clean-up.

Steam-cleaning equipment, which employees must be trained to use.

■ ANYONE WHO HAS WORKED in an institutional kitchen knows that grease and residue from cooking accumulate in hard-to-get at places around stoves, ovens, grills and ventilating hoods even though they may be cleaned daily. In some instances, this build-up reaches the point where a fire occurs in the hood or behind the stoves. Maintenance personnel generally dislike cleaning stoves and hoods by hand methods. It is time-consuming, dirty, and a complete job is impossible.

Because of these factors, the Division of Residence Halls at the University of Wisconsin decided in 1952 to use steam cleaning to periodically remove accumulated grease and cooking residues from kitchen and conveyor equipment. After some investigation and experimentation, we found that a portable steam cleaner "gun" would best serve our purposes, as high pressure steam lines were readily

Mr. Manthei is Dishroom and Sanitation Supervisor, Division of Residence Halls, University of Wisconsin

Instructions for the Operation of Steam Cleaning Equipment

A. Preparing Equipment

Steps in Operation	*Key Points to Remember*
1. Connect mixing control unit to steam supply valve in kitchen.	Make sure that safety clamps are in place.
2. Attach discharge hose to mixing control unit by means of quick coupling connections.	Make sure rubber washers fit snugly so steam or detergent can't escape. Make sure safety clamp is in place and tie with cord.
3. Attach swivel gun handle to end of discharge hose.	Make sure packing and connections are tight.
4. Connect solution intake hose to mixing control unit.	Make sure connections are tight.

B. Preparation of Detergent Solution

Steps in Operation	*Key Points to Remember*
1. Have empty 50 gallon drum adjacent to mixing control unit.	Container or drum must be clean. A large garbage can may be used.
2. Put 2 gallons of *hot* water in a pail and add 8 oz. of detergent. Stir well with *metal* paddle until dissolved.	Water must be hot and detergent well dissolved or valves will be plugged. Paddle must be metal.
3. After the above solution is thoroughly mixed, empty this solution into 50 gallon drum.	
4. Add 8 gallons of *cold* water to solution in 50 gal. drum.	Will not work properly with hot water.
5. Repeat until enough solution is made up to do the cleaning job.	Solution can be added while gun is in operation.

C. Operation of the Gun

Steps in Operation	*Key Points to Remember*
1. With one hand hold rear handle of gun. The other hand should	Make sure all connections are secure. Wear canvas gloves.

MECHANIZE 4 Scrubbing Operations into 1

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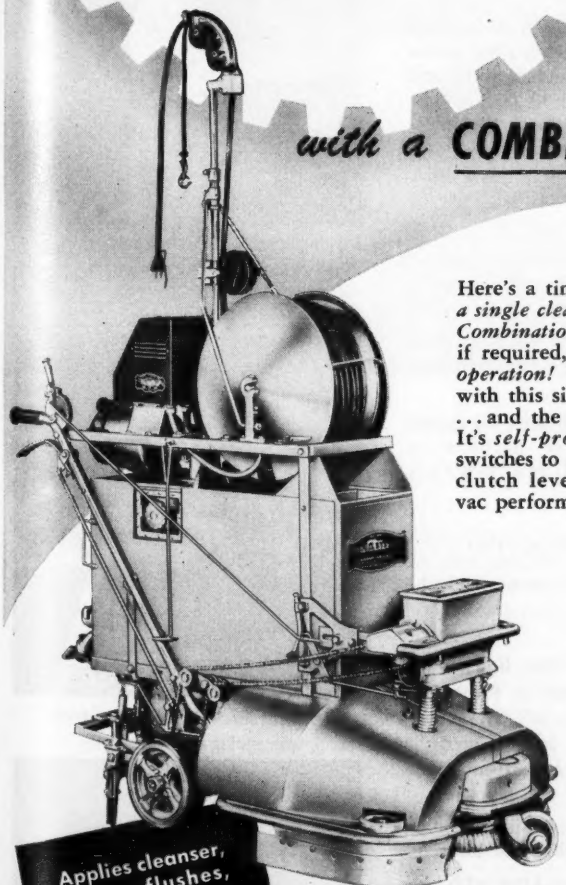

Applies cleanser, scrubs, flushes, and picks up—in ONE operation!

(Powder Dispenser and Level Cable Wind are accessories)

Here's a timely answer to the need for reducing labor costs—*a single cleaning unit that completely mechanizes scrubbing.* A *Combination Scrubber-Vac* applies the cleanser, scrubs, flushes if required, and picks up (damp-dries the floor)—*all in one operation!* Maintenance men like the convenience of working with this single unit... the thoroughness with which it cleans ...and the features that make the machine simple to operate. It's *self-propelled,* and has a *positive* clutch. There are no switches to set for *fast* or *slow*—slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs quietly.

Model 213P at left, for heavy duty scrubbing of large-area floors, has a 26-inch brush spread, and cleans up to 8,750 sq. ft. per hour! *Finnell* also makes *Scrubber-Vac Machines* for smaller and larger operations, and in *gasoline* as well as *electric* models. From this complete line, you can choose the size and model that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that you can lease or purchase a *Scrubber-Vac,* and that *a Finnell Floor Specialist and Engineer is nearby* to help train your maintenance operators in the proper use of the machine and to make periodic check-ups.

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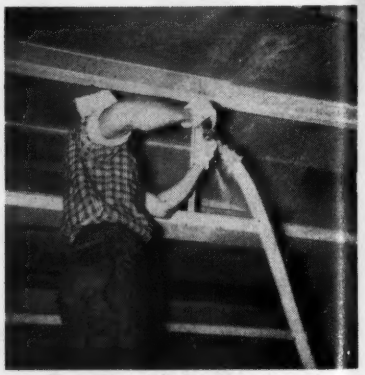
available in all of our buildings. One set of steam cleaning equipment adequately serves our four large kitchens which feed 2500 students. Steam cleaning is done in the kitchens several times a year during shut-down periods by the maintenance personnel of the particular unit being cleaned. After one unit is finished, the equipment is passed on to the next unit. When necessary, we have also cleaned kitchen equipment during operating periods after the evening meal is served.

Equipment Required

Listed below are the specific items of equipment which are used in our operation. The description of the steam cleaning equipment applies only to the make which we use.

1. One of the main requirements is the availability of a steam line with a minimum of 60 lbs. pressure, in the area to be cleaned. A shut-off valve should be installed on the steam line within six feet of where the valve box (mixing control unit) is mounted, so that in case the valve box failed, the operator could quickly shut off the steam. This has never occurred in our operation, but it is a good safety precaution.
2. "Gun" or long nozzle purchased with valve box.
3. Valve box (mixing control unit), 9" high, 8" wide, and 10" deep weighing 28 lbs. This contains the three valves used in mixing and controlling the combination of steam and detergent solution used for cleaning. (Other types of equipment use different methods of mixing the steam and detergent solution.)
4. Heavy duty ¾ inch steam hose of sufficient length to make the necessary connections and reach the area to be cleaned. Fifty feet of hose is the maximum which should be used to obtain sufficient concentration of the cleaning solution.
5. Snap-on coupling which comes with "gun" and valve box. When the hook-up is made with the couplings, we also use baling wire to tie the hose securely in place as an extra precaution.
6. Standard heavy duty vacuum cleaner equipped for wet pick-up. We had a stainless steel tank specially made for rust prevention and durability, with

Filters and small moveable equipment must be removed before cleaning.



Steaming inside large hood.

An operator in action.

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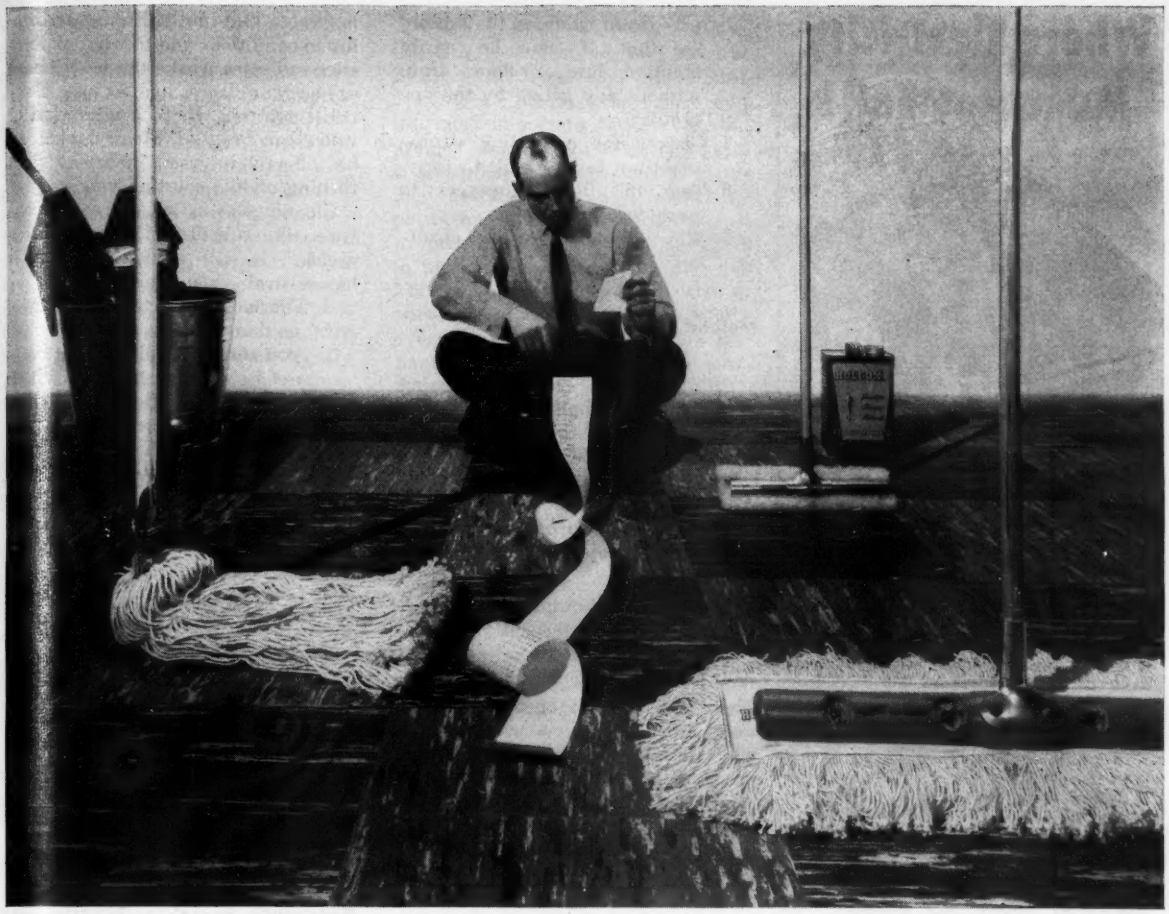
be placed on rubber handle toward nozzle of gun.

2. Nozzle should be 8"-15" from surface to be cleaned. — Exact distance depends on type of soil and type of surface. Keep nozzle moving so paint will not be taken off.
3. When ready, signal mixing control unit operator to turn on valves. — Before proceeding, be sure solution contains proper balance of detergent and steam.
4. Direct spray at angle of approximately 45°. — Keep hose away from feet. Keep out of direct spray so no particles or solution can rebound into face.

D. Operation of Mixing Valves

Steps in Operation	*Key Points to Remember*
1. *To start cleaner in operation* — check to see that all valves are closed — red, green, and blue.	Valves are closed by turning clockwise or to the right.
2. *Drain condensate*: Open blue booster valve (bottom valve) until dry steam appears, then close it.	This is done to clear the line so the mixture can be properly regulated.
3. Open green solution valve (top valve on left) wide open.	This allows the solution to enter the mixing valve unit.
4. Open red steam valve (single top valve on right) wide open.	This provides the pressure to start mixture of solution through lines.
5. Open blue booster valve until desired force of cleaning spray is obtained. Then leave in position.	This takes careful checking with operator of gun. This controls the amount of solution. Turn off for full steam.
6. Adjust green solution valve if necessary to avoid overflow of solution in drum.	This takes careful checking with operator of gun.
7. *To Stop* 1. Close blue booster valve. 2. Close red steam valve. 3. Close green solution valve.	Valves are closed by turning clockwise or to the right.



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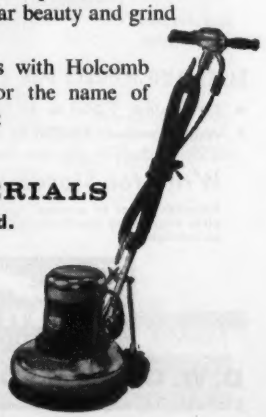

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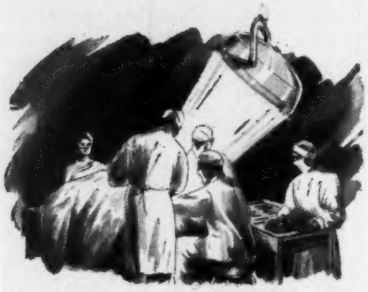

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a 1" drain valve on the bottom so that it can be easily emptied into a floor drain without any lifting by the operator.

7. Canvas for protecting equipment not to be cleaned.
8. Two 18" floor squeegees to push water to drains.
9. Mop and bucket for final clean-up.

Method of Operation

Although the steam cleaning equipment is simple, sturdily constructed and easy to operate, careful training of the personnel who will use it is extremely important. Since we have different units using it, we found it helpful to break down the job into four operations for easier training.

1. Preparing Equipment
2. Preparing Detergent Solution
3. Operating the "Gun"
4. Operating the Mixing Valves

The steps in each of these operations, which are shown were given to the maintenance supervisor of each unit. (They apply only to the specific equipment which we use, but they can serve as a guide in preparing instructions for other types of equipment.) A demonstration was then held where everyone concerned had an opportunity to go through each operation. Each supervisor then trained his own employees. In addition, each supervisor received assistance the first time the equipment was used in his unit. Better results are obtained when the same person in each unit consistently operates the gun.

Using a steam cleaner reduces the time spent in *cleaning* equipment, but it still takes time to *prepare* the area to be cleaned and to *clean up* afterward. From the standpoint of preparation, all small movable equipment which is not to be cleaned should be moved out of the immediate range of the steam cleaner. It is also desirable to cover work surfaces which will not be cleaned. A canvas may be suspended to separate the area being cleaned from the rest of the kitchen.

The vacuum wet pick-up is valuable even where there are adequate floor drains. Floor squeegees are also helpful. A final mopping of the area is always necessary.

Another point to be considered is the proportion of detergent solution to steam which should be used. This is easily controlled at the mixing valve unit and will vary according to conditions and to what experience indicates works the best. There are certain places, such as near electrical controls where a minimum of water can be used. Steam alone can be effectively used here by just turning off the solution valve.

Cleaning, even when steam pressure is substituted for "elbow grease", is still work. However, it has several advantages:

1. The most important advantage, is that with a steam cleaner you can clean places that cannot be done by hand, or which are so hard to do by hand that maintenance personnel pass over them. This is particularly true where stoves are placed back to back or very close together. Steam pressure really forces grease and residues out of cracks and crevices.
2. Laborious and unpleasant hand moves grease and dirt in minutes which would take hours to do, even if it were possible to do it by hand.
3. Additional time is saved because cleaning, being more thorough, does not have to be done as often. ■

Automatic Sprinkler Nearly 100 Years Old

■ SINCE CTESIBIUS, in the third century before Christ, invented what ancient historians called a "fire extinguishing machine", the technique of fire protection has closely paralleled advances in science and technology, and today fire protection engineering has professional status.

The greatest improvement in private protection came with the invention of the automatic fire sprinkler in 1864 by Major A. Stewart Harrison, first engineer in an English regiment. Similar devices were invented independently in this country only a little later, and it is in the U.S. and Canada that development and use of mechanical means of fire protection has flourished.

Water is the natural enemy of fire and also has the virtue of being available in practically unlimited quantities wherever groups of people live and work. While various chemicals and compounds have merit as extinguishing media, their cost of manufacture, containment, and transportation has forced the

utilization of water to optimum effectiveness so that now automatic sprinklers are made in a great variety of shapes and styles for specific hazards. High voltage electrical transformers, liquefied petroleum gases, factories producing explosives and other equally surprising fire hazards are most successfully protected with automatic sprinklers. Over 96 percent of all fires in situations where automatic sprinklers were involved in the past 60 years, have been successfully controlled. The failures were mostly attributed to lack of maintenance, protection out of service, and similar factors. Only a small fraction of one percent were due to hazards too severe for the sprinkler arrangement provided.

Popular misconceptions concerning automatic sprinklers include great water damage and frequent operation without fire. Neither has any basis in fact. Each sprinkler operates independently in incipient fire and applies water only in the small area it guards. If the fire spreads, adjacent sprinklers are involved until the fire is under control. One of the large insurance groups conducted an investigation as the number of sprinklers operating without apparent cause. Based on over 15 million sprinklers in plants they insured, on the average about one per year in each million operated from undetermined causes. Many of these were older and less reliable types which had seen long years of service.

Heating, Piping and Air Conditioning Magazine, November, 1955. ■

Japanese Physician Studies Voluntary System

■ ESTABLISHING A NON-PROFIT, voluntary community type hospital program in Japan, patterned along the lines of American hospitals, is the purpose of Dr. Genichi Kobayashi of Tokyo, the first Japanese doctor to receive a degree in Hospital Administration in the United States.

Under the personal sponsorship of the late Dr. Malcolm T. MacEachern, pioneer of hospital accreditation and crusader for better hospital administration, Dr. Kobayashi studied at Northwestern University, receiving his M.H.A. degree in 1955.

In his report on "The Comparative Study of Hospitals and Medical Systems in Japan and the United States", Dr. Kobayashi states that the most important problem in the present Japanese medical program is the prevalence of small proprietary hospitals privately owned by physicians, which makes it difficult to provide the necessary facilities to properly hospitalize the patients. This is in contrast to the American voluntary non-profit system where every physician can take his patients to hospitals and utilize the diagnostic and therapeutic facilities.

In 1952, the Japanese government made a hospital survey and it was estimated that there existed a 60,000 bed shortage. As a result of this survey, the Japanese government is planning to provide the following:

1. A general hospital of over 210 beds in each prefecture.
2. A general hospital of over 100 beds in main cities which have over 50,000 population in each prefecture and a general hospital of over 60 beds in cities which have under 50,000 population in each prefecture.
3. A general hospital of 60-120 beds in each county.

The progress of the hospitals in the United States can be attributed greatly to the social wealth and the democratic government whereby the problems of the society are solved by the people themselves, Dr. Kobayashi summarizes. It is his personal mission to impress on Japanese doctors and citizens that the responsibility for hospital welfare lies with the community. ■

Carolina Hospitals Receive Funds from Duke Endowment

■ THE DUKE ENDOWMENT allocated $253,412 to 44 hospitals in North and South Carolina for free treatment given patients in 1955. Thirty hospitals in North Carolina received $143,780 and 14 in South Carolina got $104,632. The additional appropriations went to hospitals whose applications for assistance were incomplete at the March meeting of the endowment's board of trustees at which 88 other hospitals received similar allocations. More applications not then completed were considered at the May meeting. ■

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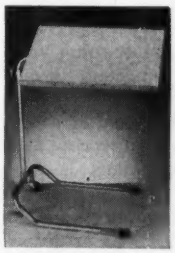

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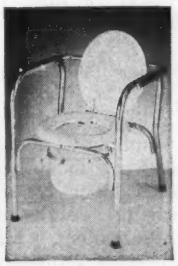

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Purchasing Agents Hold Sectional Meeting at Tri-State

by Orpha Daly Mohr

■ THE 26TH ANNUAL Tri-State Meeting has just closed. Four days of sectional and general meetings representing 36 departments within the hospital attended by 8,400 hospital people, (the largest registration to date) making the Tri-State Meeting the second largest hospital meeting in the hospital field, the national American Hospital Association Meeting being the largest.

This Tri-State Meeting had 156 exhibitors showing their products with qualified sales and research personnel in attendance to answer questions and listen to the problems of the hospital people who attended the meeting. Now comes the $64 question—Why should such a meeting be held? Why should 8,400 people connected with our hospitals attend such a meeting? Why should 156 manufacturers and suppliers set up and display their latest equipment for hospital people to examine and study? Why should 36 sectional meetings be held? There is just one reason for this: THE PATIENT — Better patient care at a lower cost.

Proper Purchasing Brings Reduced Costs

Equipment and supplies going into hospitals today are expected to reduce labor costs and give better scientific results in the treatment of the patient. Manufacturers are spending millions of dollars in research to develop such materials. Their hospital representatives must therefore be better trained in order to demonstrate and teach hospital personnel in the uses of these products. Likewise, hospital purchasing people must be better informed and constantly learning if they are going to be able to evaluate and take advantage of these developments for their particular hospitals.

The Purchasing Department sectional meeting was based on the theme: "New Products—New Trends" and "Is Cooperative Purchasing the Answer?" (It is expected that the papers and discussions carried on at this meeting will be published complete in one of our hospital publications at a later date). The answer which came out time and again was BETTER PURCHASING — between 60 percent and 70 percent of today's hospital dollar goes for payroll to personnel, thereby the 30 percent to 40 percent spent on all other phases of operation falls largely in the realm of purchases. Careful studied purchasing may reduce the payroll figure, for example $1,000 saved on paints per year may cut patient costs 3½ cents per day. In one hospital Administrator Robert Jones, who keeps complete purchasing records and follows a research program told us that by testing and securing the best paint for your particular needs labor costs may be reduced as well as the initial cost of the product. Multiples of such small savings will either reduce costs per patient days or allow development of better facilities for patient care. Hospital administrators are exceedingly conscious of operating costs and are viewing cooperative plans carefully, particularly in smaller, urban hospitals, where suppliers' and manufacturers' representatives are unable to render special services. But even so, if cooperative purchasing is to succeed in these hospitals, the hospital must set up perpetual inventory records and central ordering as well as a standardization and simplification program.

Cooperative Purchasing

Mr. Christian Lee of Norton Infirmary, Louisville, Kentucky, believes the cooperative purchasing office through the handling of routine purchasing, which does not require special services can save him time, which then can be devoted to research projects in his own hospital. Mr. Charles Loftus, Administrator of Mercy Hospital, Benton Harbor, Michigan and President of the Southwestern Michigan Hospital Council, believes the co-operative purchasing carried on by the Council has been a real service to its 62 member hospitals. They employ a thoroughly qualified purchasing agent to work with the hospitals, and he buys through the use of a research testing program and by specifications from the individual hospital. Mr. Jones of Waukesha Memorial Hospital, Waukesha, Wisconsin, 180 beds, employs a full-time purchasing agent and they also carry on a testing program and use specifications in buying, which Mr. Jones feels could not be done as efficiently through cooperative purchasing. Crayton Mann of Welborn Memorial Hospital, Evansville, Indiana, feels a cooperative purchasing plan should not be ignored, but it should be studied and carefully evaluated as to how it will fit in with your own particular hospital and medical staff.

Mr. Frank Rhatigan, Secretary of American Surgical Trade Association represented the supplier, Mr. Tom Crowely, Midwest Director, Johnson & Johnson, the manufacturer. They both stressed the importance of service and research over dollar costs. Also, the dedication of these two groups to the ultimate care of the patient within our hospitals.

The patient is the reason for each of our jobs. If we are not dedicated to that patient's well being, we should get out of the hospital field. The purchasing agent is on this team. Organized, functional purchasing is a must in today's complex hospital administration and operations. *Purchasing* — is the art of securing the largest number of units of service for the least expenditure of time, effort, and value — a maxim

Please turn to page 107

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Shopping Around

with Orpha Mohr

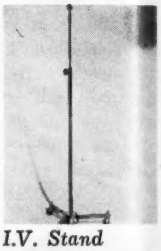
Operating Room Equipment

■ MANUFACTURERS OF surgical lights generally issue an instruction print showing where the ceiling suspended light should be hung in relation to the operating table—not necessarily, therefore, in the center of the room as has often times proven a costly mistake.

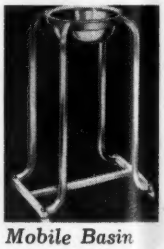
Consequently, before the contractor can install the light in the ceiling, the commonly used position of the operating table on the surgery floor must be determined. Then, and only then, is it possible to locate in the ceiling the proper position for installation of the mounting plate in preparation for hanging the surgical light.

Positioning of O.R. Furniture

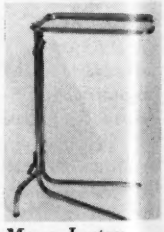
Since the operating table is the determining factor for position of not only the major light, but also of many items of accessory furniture adjacent to it—instrument tables, solution basins and anesthesia units as typical examples—where had it best be placed? Opinion on this oft neglected question is by no means unanimous; a further prob-



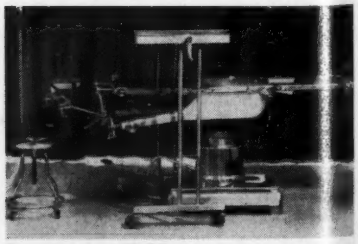
I.V. Stand



Mobile Basin Stand



Mayo Instrument Stand



Instrument Table

lem is also presented when the physical structure of the surgery suite itself complicates matters through awkward placement of the doorways leading from the surgery corridor, or the modern recessed scrub-up serving two adjacent operating rooms or from the sub-sterilizing section, and sometimes the combination of all three.

In addition, not infrequently the piping for oxygen and suction is built into the surgery without prior consideration to the table's disposition, oxygen being used at the head end rather than at the foot end of the table. An important axiom is that when planning surgeries the operating table should be drawn in first and the operating room then designed around it.

The most favorable position for the operating table is for the head end to be nearest to the doorway leading directly to the surgery corridor. Since the drape sheet hung from the anesthetic screen on the operating table is the dividing line between the sterile and unsterile fields (the unsterile field being that part of the surgery occupied by the anesthetist behind the screen), asepsis is best maintained in that part of the surgery in front of the screen by confining traffic of unscrubbed personnel and sometimes needed supplies or equipment from the corridor to this end of the room. Because the space requirements for the surgeon and his team, and for the furniture are far in excess of the anesthetist's needs in the unsterile field, the head end of the operating table would obviously be nearer the wall adjacent to the corridor-doorway than the foot end would be to the opposite wall—in other words, the table would not be in the center of the room as a general rule.

The more modern concept of the preferable operating room in the hospital's surgery suite is one with an uncluttered floor. Because all surgery apparatus, including furniture, are dirt and dust catchers their presence necessarily detracts from attaining as near close to ideal the establishment and maintenance of asepsis during the operating procedure. Each piece of furniture, therefore, should be carefully scrutinized for fulfillment of a definite and specific use, or for classification as unnecessary. If the latter, it should be removed permanently from the operating room.

Who Should Select Furniture?

Delegating the responsibility for determining what furniture may or may not be considered superfluous is, fortunately, uncomplicated. It rests with the hospital's Surgery Committee (or whatever nomenclature this group of surgeons, anesthesiologists and operating room supervisors is referred to in the particular institution); and the Purchasing Agent should be called by the committee to discuss the details of the latest offerings of the industry, many of which he has carefully examined himself at first hand at hospital and medical conventions. The Engineering Department should also be called upon to express their opinion of the structural merits of furniture under consideration and also to confirm that the recommendations outlined in *"Recommended Safe Practices for Hospital Operating Rooms", National Fire Protection Association Handbook No.* 56, Furniture, pages 56-18 and 56-19 of the May 1954 issue reprinted in 1955, are fully met.

Very comprehensive schedules of necessary surgery furniture for the surgical departments of different size hospitals are clearly set forth in *"Elements of the General Hospital"* prepared by the Division of Hospital Facilities of the United States Public Health Service. These tabulations, while somewhat scheduling on maximum requirements, are adjustable to individual needs. The following are the conventionally used items of furniture with alternates:

Sponge Rack

In many surgeries this item is considered essential. Those Surgery Committees who rule out use of this item prefer a sponge basin resting in a mobile chassis mounted on casters, into which the circulating nurse deposits all used sponges in preparation for the final count at the end of the procedure.

Mobile Basin Stand

Solution basins are procurable as single or double basin units. The single unit is in more common use for rinsing of the surgeon's hands and often times for the convenience of the scrub nurse in rinsing instruments, as an example. No golden rule dictates the quantity required in the surgery.

Instrument Tables

Generally rectangular in shape, either with or without a shelf under the table top; a choice of sizes is available and there is considerable call for their being adjustable in height. Curved instrument tables are also available. When the selection for size has been made, one table is generally considered sufficient.

Mayo Instrument Stand

One Mayo is common; but for certain procedures two stands, one on each side of the table with the ends of the trays touching (simulating an over-bed table) are often times required for reception of the instruments and supplies within immediate reach of the scrub nurse. Ease of operation of the height adjustment and assurance that the base of the stand will slide under the operating table base are two important factors.

Foot Stools

Because modern operating tables can now descend to a new low height, the operating surgeon may prefer to stand directly on the floor. The assistant surgeon, however, will request a stool to enable a better reach over the wound, particularly when the operative site is laterally located, such as in gall bladder surgery. The scrub nurse must necessarily stand on a stool since she must be on a higher level than the surgeon for fulfillment of her duties, and a double-step stool is often times in demand. On the occasion of a visiting surgeon observing a procedure, a double-step stool is also most desirable. Finally, it is highly recommended that the circulating nurse be provided with a stool for use when directing the surgical light beam into the wound—again a double-step stool is in demand for this essential use.

Kick Bucket

One kick bucket for discarded supplies fills the common need, but this item is in addition to the mobile sponge basin referred to above as the alternate to a sponge rack.

Intravenous Stand

It is advantageous that each operating room has two IV stands placed at opposite corners of the room, thus being adjacent to infusion in either the leg or the arm, or both, thus minimizing traffic were one wheeled from one end of the surgery to the other. IV stands serve also for irrigation when necessary; a further use lies in specialty surgery such as thoracic or tracheal where the surgery team is positioned virtually at

the head of the table, since the IV stand also functions as a sturdy post onto which the drape sheet is clipped thus forming an expanded anesthetic screen for separation of the aseptic and unsterile fields. An alternative method gaining favor in many institutions is suspending parenteral and blood bottles from hangers running in small flush-mounted ceiling tracks on each side of, and covering the length of the operating table. This device is also used in the recovery room.

Anesthetist's Table

Many different models are available. Those with a recessed or tray-like top insure against drug vials or pens rolling off onto the floor. There is a demand for a drawer with a good quality Yale-type lock in which to keep narcotics, thus eliminating the extra traffic and duty of having to return the unused narcotics to the pharmacy at the end of each day.

Anesthetist's Stool

There is a wide variety from which to choose and in this item individual preference is marked. Some come equipped with back rests; all should have the seat adjustable in height from the floor; and if the center portion of the seat is covered with some material such as conductive rubber sheeting, accidents from slipping off the otherwise totally polished surface will be reduced. While the operating surgeon generally stands during the procedure he will, however, invariably sit when facing the perineum in gynecologic or other operative work through the perineal route, thus a revolving stool is also necessary for this particular usage.

Utility or Pack Table

A small table is generally considered necessary for the reception of packs of sterile goods while being unwrapped just prior to transferring the sterile contents of sponges, drape sheets and the like to their respective sterile locations. This unit can also be used for the packs containing the sterile gowns and rubber gloves for donning by the surgery team. This same unit, after having served these usages just prior to the start of the operation, is often times wheeled into the unsterile area of the room behind the anesthetist for reception of parenteral fluids and other related items brought forth by the circulating nurse.

Free-Standing Cabinets

Many up to date operating rooms have built-in cabinets flush with the wall. When this item is not available, and assuming the Surgical Committee favors some such shelf arrangement, a choice of wall utensil stands is available.

Linen Hamper

While soiled linen must be removed after each operation the question of mobile linen hampers being stationed in the operating room itself is debatable.

It will be seen from the above that appreciation of the inter-relationship of the surgical light, the position of the operating table on the floor, the location of the utility outlets such as oxygen, suction and explosion-proof electrical sockets for the portable light and other electrical apparatus, has a distinct bearing on the selection of accessory furniture and its disposition in the operating room. A careful review by the Surgery Committee and its advisers will insure not only better planned operating rooms, but economies in purchasing. ■

Editor's Note:—*This material was prepared in collaboration with Mr. Adrian Comper, Director of Medical and Hospital Division of Ritter Company, Inc., Rochester, New York.*

Pictures and other equipment specifications and descriptions were furnished by manufacturers, and I wish to thank these manufacturers who so generously supplied me with technical information and photographs. *O. D. M.*

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New York 21, New York

Blickman Corp.
Weehawken, New Jersey

Boren Manufacturing Company
Menominee, Michigan

Market Forge Company
Everett 49, Massachusetts

Pedigo Welded Products
Burbank, California

Schoedinger, Inc.
Columbus 10, Ohio

Shampaine
St. Louis 4, Missouri

Swartzbough Manufacturing Company
Murfreesboro, Tennesee

Wilson Manufacturing Company
Columbus, Georgia

Chaplain Can Help "Humanize" Hospital for Patients

■ THE CHAPLAIN can play an important role in "humanizing" the hospital for patients, according to consultants for a Clergy-Hospital Conference which was held at the State University of Iowa Center for Continuation Study.

The conference was sponsored by the SUI school of religion and the graduate program in hospital administration. The Rev. Robert S. Michaelsen is director of the school of religion, and Gerhard Hartman, Ph.D. is superintendent of University Hospitals and professor of hospital administration.

Though today's hospitals are highly trusted for their technical skills, complexities resulting from medical advances and increasing size might sometimes make the patient feel that he is being treated by a machine, speakers noted. If the chaplain has developed close rapport with hospital administrators and doctors, he can help answer patient comments and provide a personal interest as well as give spiritual guidance.

Because of the chaplain's vital place on the hospital's health team, the group concluded that more conferences are needed where clergymen, hospital administrators, physicians, nurses and social workers can develop better understanding of their mutual problems. Pastors were also urged to invite doctors and other clergymen to their homes for case presentations, which would help both groups to become more effective in cooperating on future patient problems.

Abnormal releases of tensions created by a patient's rigid conscience can be the root of emotional upsets and disturbances of the respiratory system, the skin and almost any other part of the body, speakers noted. The chaplain needs to understand this if he is to help the patient find normal releases instead.

Suggested as good ways for the patient to release his tensions were the talking out of his problems, recreation, a sense of humor which will let him laugh at himself occasionally, tears and prayer. Worship and prayer were pointed out as essential to true release of tension. ■

MOHR

Continued from page 102

of Professor Willard of Northwestern University.

Mr. Jones's closing remarks were — "keep an open, searching mind and which ever method that is best for your hospital will prove out. But you must have facts and figures to work with a qualified person to do the job."

Purchasing Agents Organizing

In many areas hospital purchasing people are organizing their own associations for study and education and the exchange of ideas. It is my prediction that this movement will spread rapidly and out of it will come a real educational program. Northwestern University has given a purchasing course in its Hospital Administration program for several years. Illinois Institute of Technology offers a degree in purchasing, but their's is not pointed to institutional purchasing. The Purchasing Institutes given by American Hospital Association have been most helpful and well attended, but we still need group organization and study by local and state and later a national program centered on hospital purchasing. In April at the Texas Hospital Association Meeting, the Texas Purchasing Agents Association was formally organized. To my knowledge their's is the first state Hospital Purchasing Agents Association to be organized. The Hospital Purchasing Agents Association of greater New York has become well established this past year. There is also such a group in the Pittsburg area, and I believe a group in Connecticut was organized several years ago. The Chicago area group has been organized for approximately fourteen years, Charles Auslander being one of its founding fathers and its first president. I believe there are a number of other local organizations over the country, but I haven't sufficient information about them to mention. However, I will welcome any information concerning groups of Hospital Purchasing Agents who have formed local associations, or who are interested in doing so. As Hospital Purchasing Agents we must be ever searching and utilize every facet for knowledge and methods to carry on more efficient purchasing and better serve that all important person — THE PATIENT. ■

Interagency Institute at Walter Reed

■ THE TWELFTH INTERAGENCY INSTITUTE for Federal Hospital Administrators, sponsored by the Army, will be held at Walter Reed Army Medical Center, Washington, D.C. again this year, with 38 key hospital officials scheduled to attend.

Among the students will be commanders, deputy commanders, and executive officers of Army, Navy, Air Force, Public Health Service and Veterans Administration hospitals. Also attending will be staff officials from these agencies' central offices and personnel of Canadian federal medical services.

Objective of the Institute, according to course director Col. Byron L. Steger, is to offer senior federal hospital officials three weeks' training in (1) how to provide better patient care through better administration; (2) the skills needed to meet day-to-day problems; and (3) the latest management methods and techniques consistent with new trends in medical care. It is also hoped that the opportunity to exchange ideas and experiences with other hospital administrators and to meet outstanding authorities in the field will prove of invaluable aid to the participants. ■

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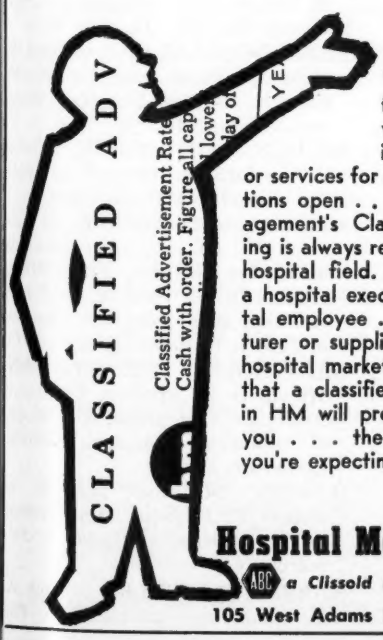

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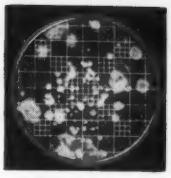

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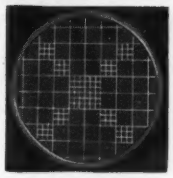

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HA Courses Announce Appointments

Northwestern University

■ THE PROGRAM IN Hospital Administration, Northwestern University, announces the following appointments to administrative residencies in hospitals for students who have completed one year of academic work and who plan to qualify for Master's degrees in Hospital Administration in June, 1957:

ANDERSON, JAMES DONALD, to Frank L. Unzicker, director of Memorial Hospital of DuPage County, Elmhurst, Ill.

BOUGHTON, GORDON SETH, to Wilbur C. McLin, administrator of Community Hospital, Indianapolis, Ind.

BURNER, LA VERNE CAROLYN, to Helen E. Sylvester, administrator of Victory Memorial Hospital, Waukegan, Ill.

BUTTARO, PETER JOSEPH, to Mortimer W. Zimmerman, executive director of Louis A. Weiss Memorial Hospital, Chicago, Ill.

BYRAM, THOMAS LESLIE, to Boone Powell, administrator of Baylor University Hospital, Dallas, Tex.

COFFEE, MAURICE PETER, to Raymond F. Hosford, director of Lankenau Hospital, Philadelphia, Pa.

COOPER, CHARLES MURDOCK, JR., to G. A. W. Currie, M.D., administrator of University of Texas Medical Branch Hospitals, Galveston, Tex.

COOPER, NEIL SHONTS, to B. F. Peterson, M.D., superintendent of Eastern State Hospital, Knoxville, Tenn.

COUTTS, ADAM, to John A. Dare, administrator of Virginia Mason Hospital, Seattle, Wash.

DAVIS, JOSEPH WALTER, to Vernon D. Seifert, administrator of Fairview Park Hospital, Cleveland, O.

DAVIS, LAWRENCE CHESTER, JR., to Edgar O. Mansfield, superintendent of White Cross Hospital, Columbus, O.

DEVINS, JOHN PETER, to David A. Endres, administrator of The Youngstown Hospital Association, Youngstown, O.

DONNELLY, PAUL ROLLIN, to Norman D. Bailey, executive director of Grant Hospital, Chicago, Ill.

DURR, JERRY LAMAR, to David B. Wilson, M.D., director of University Hospital, Jackson, Miss.

EITEL, DOUGLAS RAE, to Reid T. Holmes, administrator of North Carolina Baptist Hospital, Winston-Salem, N.C.

ERLMAN, JOHN ARTHUR, to John E. VanderKlish, director of Malden Hospital, Malden, Mass.

FINGER, MARY LOUISE, to Edward W. Gilgan, superintendent of Hurley Hospital, Flint, Mich.

FURIE, EDGAR PHILIP, to David H. Ross, M.D., executive director of Jewish Hospital, Cincinnati, O.

GREATHOUSE, JOE STEPHEN, JR., to S. A. Ruskjer, Chairman Preceptor Committee, University of Louisville Medical Center, Louisville, Ky.

HANSEN, DONALD ELMER, to Robert F. Bilstein, administrator of The Bismarck Hospital, Bismarck, N.D.

HARVEY, ELMER LEE, to Jack A. L. Hahn, superintendent of The

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Universal dishwashers pay their own way with these cost-saving, better washing features. Different sized models with Swing-Wash, revolving wash or pressure equalized wash • Complete coverage revolving final rinse • Built-in Final Rinse Water Booster heaters, steam, gas or electric operated for required 180° final rinse • Better sterilization — Faster drying • Automatic timed wash and rinse control units.

Save labor cost — insure better, more uniform sanitation with Universal Type Dishwashers.

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World's Largest Exclusive Producer of Commercial Type Dish, Glass and Silver Washing Machines

WHO'S WHO

Continued from page 67

Hospital in Jefferson, Iowa. She succeeds ERNEST JOHNSTON.

ROSS, DR. DAVID H.—Appointed assistant professor of Hospital Administration in the Department of Preventive Medicine and Industrial Health, College of Medicine for the University of Cincinnati in Cincinnati, Ohio. He has been in the executive directorship position at the Jewish Hospital Association since 1947.

SARGEANT, (MRS.) RAYMOND E.—Was elected president of the board of trustees of the Children's Hospital in Denver, Colorado.

STANTON, ALEX F.—See GENEL notice.

STEVENSON, DALE—Appointed chief pharmacist at the Reading Hospital in Reading, Pennsylvania. He was formerly master pharmacist at the University Hospital in Ann Arbor, Michigan. He succeeds PHILIP MABOLL who is now chief pharmacist at the Strong Memorial Hospital in Rochester, New York.

STUART, LENORE BERTOLETTE—Appointed administrator of the Cross County Hospital in Yonkers, New York. She was formerly administrator at the Memorial Hospital in Queens, Long Island.

PAUL, ELMER W.—Appointed administrator at the Burge Hospital in Springfield, Mo.

THOMPSON, GEORGE M.—Elected president of the board of trustees of the Cedars of Lebanon Hospital in Los Angeles, California.

TOSH, WALTER J.—Resigned as superintendent of the State Hospital in Hazelton, Pennsylvania.

TREWHELLA, ARTHUR PAUL—Appointed assistant administrator of the Beekman-Downtown Hospital in New York, New York. He succeeds JULIE I. KEOGH, who is retiring.

TYSON, MONTY H.—See GENEL notice.

VAIL, JAMES E.—Appointed to the newly created post of public relations director of University Hospitals of Cleveland, Ohio.

VOLLMER, FRED J.—Appointed to the board of trustees of the Hahnemann Hospital in Philadelphia, Pennsylvania. Also appointed to the board was JOEL DAVIS JR.

WELLS, (MRS.) I. J. K.—See LINEWEAVER notice.

WEISSMILLER, DR. LESTER L.—See LEVEROOS notice.

WRIGHT, CARNEY W.—Appointed administrator of the Riverside Hospital in Paducah, Kentucky. He was formerly business administrator of the Tennessee Tuberculosis Hospital in Chattanooga, Tennessee.

ZIMOSKI, HERMAN F.—Appointed business manager for the Kaiser Foundation Hospital in Fontana, California.

DEATHS

BRUCE, LEROY R.—61 years old, former director of the Los Angeles County General Hospital in Los Angeles, California, died recently at his home. His death was attributed to a heart attack.

CARTER, DR. FREDERICK—67 years old, former president of the American Hospital Association in Cleveland, Ohio, died at his home in suburban Shaker Heights, Ohio.

CONSTANCE, MOTHER M.—Administrator of the Sacred Heart Hospital in Manchester, New Hampshire. She was formerly administrator at our Lady of Perpetual Help Maternity Hospital, the obstetrical unit of the Sacred Heart Hospital.

CRAWLEY, (MRS.) GRACE—Retired financial secretary of the Skin and Cancer Unit, University Hospital, New York University-Bellevue Medical Center, in New York City, New York, died after a cerebral hemorrhage. She was 79 years old.

HOLBROOK, FRANK WINDER—60, former liaison officer of Petersburg General Hospital in Petersburg, Virginia, died of a heart attack at his home.

NEIL, DR. MARY PAULSON—83, one of the founders of the Hinsdale Sanitarium in Chicago, Illinois died on March 11.

SISTER MARY AGATHA—81 year old Mother Superior at Mercy Hospital in Chicago, Illinois, died in that hospital. She was associated with the hospital for 27 years. ■

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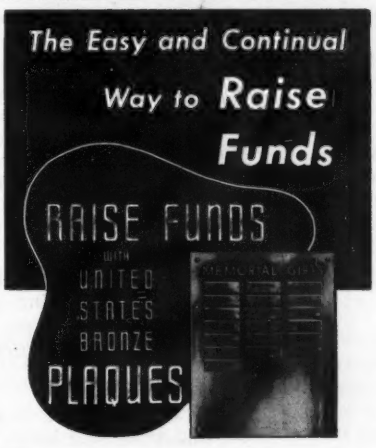

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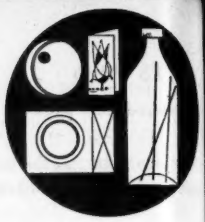
Product News and Literature



701 — **Insulated Jug**

■ THIS INSULATED JUG has a built-in pump dispenser, and is available in one half and one gallon sizes. Just a squeeze of the red rubber bulb and the liquid is pumped through a spout at the top of the jug. It is designed in bright red, yellow and black Skotch plaid, with a red plastic handle. The insulation is fiberglass. Ice cubes may be used with the jug without their interferring with the pumping action. This jug sports a removable magnetic stopper which fits into the spout. When drinks are requested, simply place the stopper against the jug's metal surface and it sticks; it is impossible to misplace and handy for reuse.

702 — **Bethesda TPR Board**

■ THE BETHESDA TPR Board has been carefully shaped to fit comfortably against the nurse's body when in use. Compactly arranged on the board, and firmly attached to it, are a TPR data pad, an electronic therma meter, a full face watch with sweep second hand, a battery-powered night light and a pencil clip. The therma meter is a new electronic method of reading temperatures. It features a practically unbreakable metal probe which, when inserted, transmits temperature readings to the large dial on the therma meter itself. Accuracy is to within one-tenth of one degree. Pulse and respiration readings are taken with the aid of the watch on the Bethesda TPR Board. For night readings, the board may be illuminated with the small night light, making it unnecessary to turn on room lights or disturb other patients.

703 — **Folding Steel Legs**

■ THESE FOLDING STEEL legs are designed and engineered to produce a reciprocal gripping lever action on a standard 2″ x 4″, when legs are opened or spread at the bottom. The legs are fabricated from ⅛″ angle iron with all moving parts riveted. They are reported capable of supporting from 500 lbs. to 2,000 lbs. in pairs, depending on their height. They are available in pairs of 14″, 25″, 30″, 36″, 42″ and 48″ heights. Special sizes can be produced to specifications.

704 — **Power Mower and Mulcher**

■ THIS NEW HEAVY-DUTY power mower and mulcher has a full 19″ cutting width. Its built-in mulcher shreds the cut grass to a powder, then evenly spreads the valuable mulch between grass blades to fertilize the lawn. It has recessed wheels, permitting mowing to within ¼″ of fences, buildings and other obstacles. A suction-lift blade bar pulls grass upright, then whacks it off to assure a smooth even cut. The safely enclosed blade is fully surrounded by the sturdy steel housing. The unit has a 1¾ HP, fast starting gasoline engine. Cutting height is quickly adjustable from 1″ to 3″. By removing the front safety guard, weeds 10′ high can be cut. The mower is finished in durable baked enamel.

705 — **Triangular Brush**

■ THIS TRIANGULAR BRUSH permits the maintenance man to clean every nook and cranny, but speeds up damp sweeping of the entire floor. A special double swivel connects the 5 foot aluminum handle to the triangular brush at its center. This provides flick-of-the-wrist maneuverability. The user may change direction at any time without lifting the implement from the floor.

706 — **Thermal Alarm**

■ THE THERMAL ALARM provides an immediate audible or visual warning signal when the post-operative patient's rectal temperature rises or falls to a previously selected point, thus calling attention to the need for temperature control measures. This compact unit uses a temperature-sensing thermistor in an unbreakable rectal probe at the end of vinyl-insulated leadwire that is rugged, yet flexible. Provision is made for convenient connection of external and remote signaling. A carrying handle allows easy transportation.

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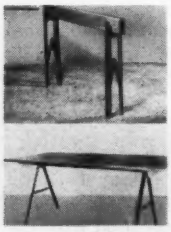

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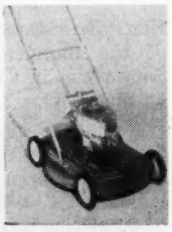

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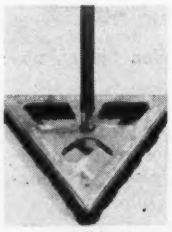

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706

707 — Heater with Built-in Auto-Transformer

■ THIS HEATER WITH a built-in auto-transformer, provides stepless control of power input from 0 to 750 watts. The durable coil of nickel-chromium used in the new heater produces quick heat (450 ml. of water boils in 5.9 minutes); a calibrated dial permits reproducibility of power input to within 1.6 watts across the entire range. The refractory top is reversible and beveled to a different diameter on each side, permitting use of various size flasks. Ribs on the bevels leave air space under the flask, promoting heating efficiency and preventing glassware breakage.

708 — Drug-Stower

■ THE DRUG-STOWER is a compactly built cabinet into which 360 feet of shelving is engineered, yet it occupies a mere 4'6" by 4'6" area of floor space. Incorporating a novel arrangement, there are 180 various sized compartments that form a circular, vertical tier which can be rotated, thus affording complete accessibility from one given point. Each compartment contains a removable "stow" drawer and all drawers are numbered to facilitate indexing and for instant locating of a desired drug. The revolving section rotates freely in either direction with minimum effort on large ball thrust bearings mounted on steel angles. A built-in foot brake located in the base of the cabinet provides a convenient and smooth stopping device.

709 — Hospital Broadcaster

■ THIS HANDSOMELY DESIGNED and carefully engineered piece of equipment which makes it possible for hospitals to originate and broadcast their own radio programs from a studio room located within the hospital to a patient's remote control pillow radio. Hospitals may transmit live programs, tape recorded programs or programs on records as well as any A-M or F-M radio stations desired. The new system makes it possible for all programs to be received by patients without any wiring to the patient's rooms. Electronic transmission eliminates the need for direct wiring. The same equipment can be used to prepare and transmit programs to loud speakers located in lobbies and waiting rooms, and in working areas such as central supply, laundries etc. The equipment may also be used as a paging system for hospitals.

710 — Protective Coating for Asphalt Tile

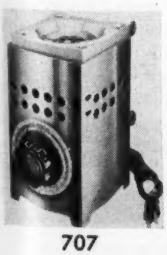
■ THIS NEW SELF-POLISHING floor finish is made especially for asphalt tile. It will not streak, spot or cause bleeding of asphalt tile. Low oxidation permits sectional patching of worn surfaces. It is also water resistant. Its high lustre is not affected by water up to 125°F.

711 — Sliding and Tilting Wheeled Stretcher Saves Time and Motion

■ THE LATEST TWO-WAY sliding and tilting unit comes with a large group of accessories. It can be used as an emergency operating table. With the sliding and tilting feature, one attendant can transfer the patient from the stretcher on to the x-ray table or on to the bed, with no stress or strain to either the patient or the attendant. The manufacturer claims that the patient has been given the ultimate in safety.

712 — Radio Paging System

■ THIS RADIO PAGING SYSTEM serves to locate personnel quickly in locations or situations where conventional paging systems are undesirable or ineffective. Principal feature of this paging system is a small radio decoder, about the size of a pack of cigarettes. Each such decoder in a radio paging system responds to a certain coded radio signal. When it receives that signal it emits a pleasant audible tone, which is a message to the individual carrying or using that particular decoder that he is being paged. The decoder measures only 2½" x 3⅝" x 1", and weighs only 7 ounces. It has a colorful, smooth plastic case, and can easily be carried in a shirt or coat pocket. It is completely self-contained, with no external wires or other attachments. Power is supplied by a special compact power pack which can operate the decoder for several weeks.



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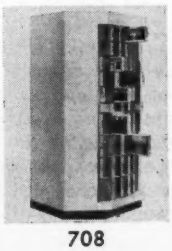

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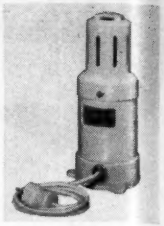
712

713 — Ozonator

■ TO OXIDIZE OR "BURN UP" offensive odors, this ozonator introduces pure controlled ozone into the air. It eliminates odors, and will inhibit the growth of mold and mildew and act as an effective bacteria control. Ozonators reduce waste, eliminate shrinkage, sweat, smear and slickness. Ozonators preserve longer the natural bloom and freshness of meat. Produce has that "garden-fresh" appearance. Fruit can now be kept from ripening too fast. The complete unit weighs only three lbs.



713

714 — Waste Can Liners

■ THE STEP-ON WASTE can bags have a heavy wax coating to protect against leakage and contamination, and have a pine odor to provide a pleasant scent and avoid any disagreeable odor from the contents. The plastic bags are expected to have many uses for storage in doctors' offices and hospital supply departments. Each plastic bag holds fifty can liners, available in three sizes to fit 10 to 14 quart cans, 16 to 20 quart cans, and 24 to 30 quart cans and containers.

714

715 — Embossed Paper Napkin

■ HOSPITALS, CLUBS, RESORTS, hotels and restaurants may now have their insignia custom embossed on these paper napkins which come in white or pastels. The embossing makes a very rich appearance and provides a subtle form of advertising agreeable to both server and customer.

715

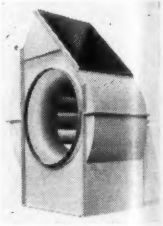
716 — Book Stand

■ THIS BOOK STAND ELIMINATES the inefficient and back-breaking lugging of heavy books. Through the device of balanced spring action and floating top panels, the new book stand automatically levels the pages of bulky books, making all pages equally easy to read. It is quickly adjustable to desired height; top swivels for use by more than one person, and transports effortlessly and quietly on 2 inch ball bearing casters. Occupying only 16″ x 21″ floor space, the book stand adjusts from 27″ to 41″ in height and instantly locks by turning two easy-to-grip knobs. The floating top adjusts both laterally and vertically to accommodate either stiff or flexible bindings. It is available in five colors: silvertone gray, walnut brown, dark office green, mist green or beigetone.

716

717 — Centrifugal Fans

■ THESE FANS ARE designed for a wide range of commercial and industrial ventilating, air conditioning and heating applications. These fans give top efficiency and low noise levels. A wide range of wheel diameters is available in both type "B" backward curved fans and type "F" forward curved fans. The "B" type fan has a backward curved, flatbladed wheel with non-overloading characteristics. The type "F" fan has a forward curved, multibladed wheel for slow speed operation. Both types are available with direct or V-belt drive.



717

718 — Sanitizing Wax

■ THIS SANITIZING WAX is a high quality water emulsion wax that dries to a hard brilliant shine and can be rebuffed periodically to renew the gloss. Actual controlled field tests proved that this sanitizing wax reduced the bacterial count 99½% even after the 7th day following application. It can be used safely on all types of flooring materials.

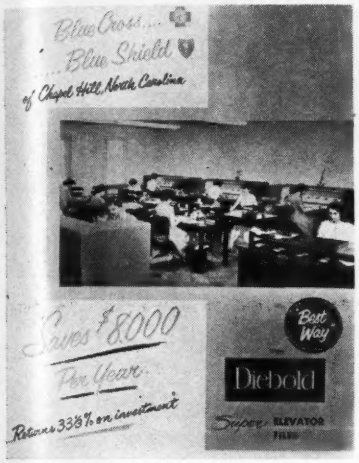
719 — Plastic Container for Gravity Blood Collection

■ A NEW PLASTIC CONTAINER for collection of 450 cc. (475 Gm.) of blood by gravity, is a disposable, non-wettable, pliant and tamper-proof plastic bag. It is designed to save space and facilitate handling, it can be centrifuged in a standard 500-cc. water-filled cup. The self-collapsing bag obviates the need for an air-intake needle and eliminates risk of air embolism. It permits application of external pressure for transfusion. The set consists of 36 inches of plastic tubing, pinch clamp and attached silicone-treated 15-gauge stopper-piercing needle and 15-gauge vein needle.

719

Management Aids

Case History on Motorized Files



■ A COLORFUL FOUR-PAGE case history analyzes the experience of a Hospital Saving Association in using Diebold Super Elevator Files to improve handling of application and claims records. Clerical expenses and time were cut by a large percentage. It was possible to centralize data, thus creating a rise in operating efficiency.

Circle 720 on mailing card for details.

Decorator Paints

■ IN AN ATTRACTIVE BROCHURE issued by Cook's Paints, the decorator is enabled to select colors in complementary or related harmonies. A color chart is arranged with contrasting colors on a diagonal line and related colors on horizontal and vertical lines. The brochure also points out that the company's paints are lasting, scrubbable and easily applied.

Circle 721 on mailing card for details.

"Medical Engineering"

■ THIS SIX-PAGE ILLUSTRATED folder is a reprint of an article from "Research and Engineering". Written by Renato Contini, research coordinator in the New York University Engineering Research Division, it discusses the historical development of medicine and engineering, the areas of present cooperation between them, and the potentialities for further cooperation.

Circle 722 on mailing card for details.

"Danger In The Heat Zone"

■ TEMPERATURES IN MODERN diesel engines often reach 3600°, leading to heat prostration in vital parts. "Danger in the Heat Zone", a booklet published by Caterpillar Tractor Co., discusses how this can be avoided through sound metallurgy and careful machining. In eight illustrated pages this booklet describes the design, processing to specifications, machining to close tolerances and rigid inspections required to insure long engine life.

Circle 723 on mailing card for details.

Non-Shrink Mortar

■ A 7-STEP PROCEDURE for repairing concrete floors with non-shrink mortar is described in a folder released by the Master Builders Company. Each step is illustrated with an actual photograph and description of the step involved. The mortar is ready-to-use and requires only mixing with water at the time of use. According to the manufacturer, the mortar does not shrink upon hardening as plain mortars do, bonds tightly to old concrete and repairs made with the material have high compressive and flexural strengths. Actual strength comparisons between plain mortar and this product are given in the folder. Iron particles serve as reinforcement, so that the hardened mortar is extremely tough.

Circle 724 on mailing card for details.

Industrial Exhaust Fans

■ A TWO-COLOR ILLUSTRATED four-page catalog describing Ventura Fans for commercial and industrial ventilation has been published by the American Blower Corp. The catalog discusses features of the V-belt-driven fans and their application. Tables of performance data are included which list electrical power requirements, delivery ratings at different static pressures, fan speed, motor horsepower, nominal rotor diameter and net weight for each of the different sizes and models.

Circle 725 on mailing card for details.

Bed Accessories

■ THIS SIX-PAGE FOLDER describes and illustrates the bed accessories available from the Gilbert Hyde Chick Company. The equipment described includes the crib fracture set, bucks, cervical traction set, monkey bar, patient helper and patient roller. Photographs and diagrams show the uses of the equipment.

Circle 726 on mailing card for details.

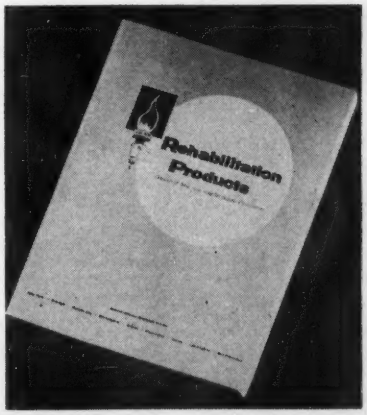
Porcelain Laboratory Sinks

■ THIS 20-PAGE, THREE-COLOR bulletin fully illustrates U.S. Stoneware's complete line of Chemical Porcelain Sinks. Photographs and dimensional drawings show how the sinks are made and their uses. The bulletin also includes charts of specifications.

Circle 727 on mailing card for details.

Rehabilitation Products Catalog

■ DESIGNED TO BE a complete source for rehabilitation and physical therapy equipment, this 150-page catalog is published by the Rehabilitation Products Division of American Hospital Supply Corporation. Over 750 products are illustrated and detailed, including equipment for electro, hydro and heat therapy; diagnostic, exercise, respiratory and self-help items; furniture; mobile units; orthopedic equipment; sundries and miscellaneous general hospital items. It contains a complete index with all products listed in a convenient numerical system.



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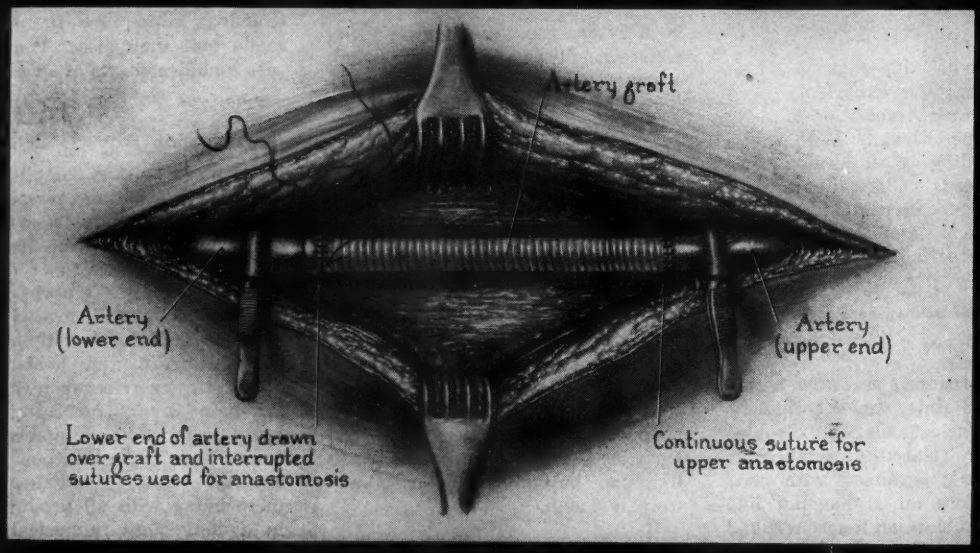
The Edwards-Tapp ARTERY GRAFT

FOR REPLACEMENT OF DISEASED OR DAMAGED VESSELS
MADE FROM CHEMICALLY FUSED, BRAIDED, NYLON FIBER

READILY AVAILABLE IN VARIOUS SIZES—EASILY SUTURED—
WILL NOT KINK ON FLEXION

SIZES AVAILABLE: 3/16", 1/4", 5/16", 3/8", 1/2", and 3/4" I.D.
A.C.M.I. No. 2400 • Lengths—10" and 20"


Artery graft
Artery (lower end)
Artery (upper end)
Lower end of artery drawn over graft and interrupted sutures used for anastomosis
Continuous suture for upper anastomosis

1. The Edwards-Tapp Arterial Grafts can be used in flexion areas, popliteal space, axilla, groins and as a by-pass graft in areas of obstruction.

2. Kinking is prevented by corrugating the chemically fused nylon fibers during fabrication.

3. Chemical fusion of the nylon fibers reduces porosity, prevents blood loss, permits fibroblast penetration.

4. Arterial Grafts are readily sterilized by autoclaving.

5. Readily sutured, the arterial grafts are cut to size at the operating table and the ends heat sealed by hot cautery to prevent fraying.

References

Edwards, W. Sterling and Tapp, James S.: Chemically Treated Nylon Tubes as Arterial Grafts, Surgery 38: 61-70, 89-91 (July) 1955.

Edwards, W. Sterling and Tapp, James S.: Peripheral Artery Replacement with Chemically Treated Nylon Tubes, Surg., Gynec. & Obst. 102: 443-449 (April) 1956.

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FREDERICK J. WALLACE, President

American Cystoscope Makers, Inc.

1241 LAFAYETTE AVENUE NEW YORK 59, N. Y.

H. A. RESIDENCIES

Continued from page 108

Methodist Hospital, Indianapolis, Ind.

HUTCHINSON, JOSEPH IRWIN, to Lawrence Payne, administrator of Baptist Memorial Hospital, Jacksonville, Fla.

JOHNSON, THEODORE HAROLD, to Herbert R. Rodde, administrator of Highland Park Hospital, Highland Park, Ill.

KING, HAROLD VERNON, to Raymond F. Farwell, administrator of The Swedish Hospital, Seattle, Wash.

LENZ, WARREN JAY, to S. A. Ruskjer, Chairman Preceptor Committee, University of Louisville Medical Center, Louisville, Ky.

LEUTHARD, WILLARD JOHN, to Alfred E. Maffly, administrator of Herrick Memorial Hospital, Berkeley, Calif.

MORENO, RODRIGO ALBERTO, to Thomas W. Fourqurean, administrator of Brackenridge Hospital, Austin, Tex.

OLING, MARIE NETTIE, to Paul W. Kempe, administrator of Silver Cross Hospital, Joliet, Ill.

O'QUINN, HANSEL BENSON, to Freeman E. May, administrator of Baptist Hospital, Alexandria, La.

POST, GLADYS ELAINE, to Edmund J. Shea, administrator of Indiana University Medical Center, Indianapolis, Ind.

PROANO, JAIME ANIBAL, to L. B. Dana, administrator, of Knickerbocker Hospital, New York (Bronx), N.Y.

RAPPAPORT, MARVIN, Los Angeles, (unassigned)

SHAW, MAURICE BRYAN, to Phil Carter, administrator of The Methodist Hospital, Lubbock, Tex.

SKOMSKY, GEORGE, to Lawrence E. Kresge, administrator of Auburn Memorial Hospital, Auburn, N.Y.

SLEDGE, VICTOR MARCEL, to Gene Kidd, administrator of Baptist Hospital, Nashville, Tenn.

SMITH, DAVID MARION, to B. Tol Terrell, administrator of Shannon West Texas Memorial Hospital, San Angelo, Tex.

STAINBACK, RICHARD CHARLES, to Merrill F. Steele, M.D., superintendent of Christ Hospital, Cincinnati, O.

TALBERT, BILLY RALPH, to Joseph P. Greer, director of St. Luke's Hospital, Chicago, Ill.

THAL, RICHARD OTTO, to T. Ray Jones, administrator of North Mississippi Community Hospital, Tupelo, Miss.

VAN SLYKE, WILLIAM HARRY, to Raymond K. Bolinger, administrator of Robert Packer Hospital & Guthrie Clinic, Sayre, Pa.

WILPITZ, ROLAND WILLIE, to John E. Paplow, administrator of Santa Barbara Cottage Hospital, Santa Barbara, Calif.

WOLOTSKY, DOV, to Mark A. Freedman, M.D., executive director of Beth Israel Hospital, New York, New York. ■

University of Minnesota

DONALD F. ANDREWS, Bethesda Hospital, St. Paul, Minn., Kenneth Holmquist, Superintendent;

J. RICHARD ARNZEN, Rhode Island Hospital, Providence, R.I., O. G. Pratt, Executive Director;

PAUL C. BALCOM, Johns Hopkins Hospital, Baltimore, Md., Russell O. Nelson, M.D., Director;

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GERALD W. FRAWLEY, University of Minnesota Hospital, Minneapolis, Minn., Ray Amberg, Administrator;

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JOHN R. JEFFERIES, Stormont-Vail Hospital, Topeka, Kansas, Carl C. Lamley, Executive Director;

ROBERT L. JEPSEN, Memorial Hospital of South Bend, South Bend, Ind., Richard M. Trenkner, Administrator;

Please turn to page 119

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Continued from page 83

ning the needled-out cards on an adding machine.)

The McBee cards are used as posting media to patients' accounts. Actual posting is done on a standard National "Class 31" hospital accounting machine. As shown in Figure 1, a patient's statement and three copies are printed simultaneously, a journal being created at the same time. The posting operation consists of picking up the patient's old balance and entering charges "right across the line," directly from the McBee cards. The machine prints the new balance automatically and accumulates the various kinds of charges (X-Ray, Laboratory, Supplies, Drugs, Room and Miscellaneous) in individual totals, which provide the basis for posting the day's income to our income ledgers (Figure 2). The income ledger posting is also a machine operation; the ledger cards are so arranged that we have the figures for both in-patients and out-patients on the same card.

The multiple-copy statement form used is acceptable to the Blue Cross and other insurance companies, so we use it for all in-patients, whether insurance is involved or not. Posting of out-patient accounts is accomplished in the same manner, on a form that, for all practical purposes, is identical.

Before posting the income ledgers, a further analysis of the miscellaneous charges is made, directly from the McBee cards; this takes but a few minutes and gives us a fine breakdown of income.

Incoming Cash

As in most hospitals, we usually have advance notice of when a patient is going to leave, so that we have time to down-add the columns on his statement and compute the Blue Cross (or other insurance) portion that will be paid, as well as the amount due from the patient himself.

At the cashier's window, we have an NCR "41" machine designed to control and classify all cash receipts. There are six individual control buttons at the right side of this machine:

In-patient
Out-patient
Discharged Patient
Notes Receivable
Cafeteria
Employee

Each of these buttons or keys adds into an individual total. Operation is exceedingly simple. The cashier inserts a receipt form like the one shown in Figure 3, indexes the amount paid, and touches the proper control button. This instantly causes the receipt to be machine-validated in two places, and the amount to become locked into the appropriate total.

The patient is given his portion of the receipt and the voucher half is retained by the cashier, to be used as a posting medium to the statement. Statements are not given to patients as they leave, but are mailed out to them later, showing the payment made. The reason we retain them is that there may be late charges as yet unposted. When the patient is discharged, we add these late charges to the balance due as shown by the statement in order to quickly compute the amount due; the actual posting to the statement can then be made later on, along with the charge postings and other payments for that day. This makes for a smooth operation, and we have encountered no objection to the idea of mailing out the statements, particularly since the patient is given a machine-validated receipt, as he leaves, for any payment made.

If a patient gives a note in lieu of cash, any future payments made are registered through the Note Receivable button. Similarly, payments made by patients already discharged are entered through a separate control key.

Balancing cash at the end of the day is an easy matter, since the machine yields totals for all cash taken in; these are printed automatically on a Daily Cash Report. The In-patient, Out-patient, Discharged Patient and Notes Receivable totals also act as controls over later postings to individual accounts. No cash posting can be made except from a machine-validated voucher.

Accounts Payable and General Ledger

We feel that our accounts payable work, also done on the "31" typewriter-bookkeeping machine, is worth mentioning, since vouchering and distribution are accomplished in the same operation. As illustrated in Figure 4, the voucher-remittance advice is prepared at the left, showing date, invoice numbers, amounts being paid, deductions and total new balance. Invoice amounts are then immediately distributed to the proper distribution ledgers at the right, the new balance and year-to-date purchases being automatically computed and printed by the machine in each instance. After all of one vendor's invoices have been vouchered and distributed in this manner, the machine prints a ".00" proof in the extreme right column of the journal, showing that the amounts vouchered are in balance with the amounts distributed, and that old balances were picked up correctly. Journal columns accumulate vertically as postings are made.

We have only about 100 accounts payable postings a week, so this job is a once-a-week operation for us. Nevertheless, it is incomparably faster and more accurate than a pen-and-ink set-up.

Checks, too, are written by machine (Figure 5), a Check Register being produced as a by-product of this operation. The checks are automatically dated and numbered as they are written.

The entire general ledger is posted on cards identical to the one pictured in Figure 4. Balances for both month and year to date are immediately available on any general ledger account; further, the records are in highly legible form and in absolute proof at all times.

Payroll

The payroll job, illustrated in Figure 6, is another "extra" we obtain from our hospital accounting machine. Note that all records—earnings record, pay statement, check, payroll journal and check register—are written at one time. Gross and net pay are figured automatically, and to-date balances for earnings, F.I.C.A. and withholding tax are printed on each earnings record. The journal totals, including individual totals for all deductions, add vertically as the payroll is written. Names are typed on checks and journal by means of the machine's electric typewriter.

The payroll is actually run off by departments (Administrative, Dietary, Housekeeping, and so forth) and totals cleared at the end of each department; this gives us an automatic departmental breakdown of payroll expense. We have 103 people, paid semi-monthly.

Summary

In the writer's opinion, it is *not* necessary to have a large volume of work in order to justify machine accounting. Even the bookkeeping requirements of a relatively "small"

hospital can become amazingly confusing and complex under a pen-and-ink system.

Machine accounting has three major advantages: (1) many related records are prepared at one writing, instead of in separate operations; (2) all addition, subtraction and computation of balances is accomplished automatically, and (3) records are up-to-date and in proof at all times. As a corollary, it might be mentioned that there is no problem of *tying in* related records, since they are prepared at the same time; and there is no month-end peak effort. Also, a far greater degree of control is provided, and it is easier to train personnel. All of this would seem to be worth some increase in bookkeeping costs; but the fact is that mechanization almost invariably results in a *reduction* of costs, and justifies itself on this basis alone. ■

Health Insurance Functions Well In Sweden

■ SWEDEN'S SYSTEM of general health insurance during its first year of existence cost between 70 and 80 million kronor less than expected, according to preliminary but reliable estimates. Income, on the other hand, was somewhat larger. Wage and salary improvements during the year were greater than expected, and both contributions from employers and indivdual premiums, therefore, reached totals exceeding the original estimates.

By and large, the general health insurance has made a good start, the newspapers agree. One of the reasons for the lower costs is the fact that Sweden last year was spared from serious epidemics, and that the people in general enjoyed good health, observes the Conservative *Svenska Dagbladet*. Many useful experiences have been gained, this paper adds, and it is gratifying to note that the enormous machinery, after an initial grinding of wheels, now seems to function quite well. There was some reason to fear abuse of the system, but such cases seem to have been rare. Some details, however, will have to be revamped, according to the leading Conservative organ, and a thorough examination of the entire setup will be needed before the compulsory health insurance can be said to be in perfect order.

The general health insurance, which became effective on January 1, 1955, provides for free care in a hospital ward and the payment of cash benefits for up to two years, greatly reduced costs in the case of treatment by a private physician, and help with the cost of medicine and expenses for transportation. Special allowances for children and cash benefits for sick housewives add to the family protection against ill health. The health plan also covers the first ninety days of industrial injuries, against which all wage earners have long been insured by the employers. After that period disability benefits will be paid under a special law. According to estimates made when the general health insurance took effect, about 44 percent of the costs would be covered by individual annual premiums, while the government, that is, the taxpayers, would contribute 29 and the employers 27 percent. ■

H. A. RESIDENCIES

Continued from page 117

EDWARD R. LYNN, Abbott Hospital, Minneapolis, Minn., Frank R. Briggs, Administrator;
WILLIAM H. MALOY, Highland Hospital, Rochester, N.Y., Marie J. Doud, Administrator;
ROBERT G. MICHAELS, Mt. Sinai Hospital, Minneapolis, Minn., B. W. Mandelstam, M.D., Administrator;
CLARENCE W. PALMATEER, St. Luke's Hospital, Duluth, Minn., Richard Fox, Superintendent;
MARK H. TIBBETTS, St. Luke's Hospital, Milwaukee, Wisc., Merton E. Knisely, Administrator;
HAROLD V. WEED, Charles T. Miller Hospital, St. Paul, Minn., William N. Wallace, Administrator;
FREDERICK R. WOLF, Swedish Hospital, Minneapolis, Minn., Raymond K. Swanson, Superintendent;
DONALD F. ZUERCHER, Fairview Hospital, Minneapolis, Minn., Carl N. Platou, Administrator.

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Graduates of the course in hospital administration at Northwestern University, Chicago, Illinois.

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ADMINISTRATORS—BUS MGRS—CLINICS: (a) Bus Mgr; acctng & hosp exp; vol gen hosp 300 beds; to $7500; univ city; S. (b) Bus Mgr; new hosp completion early '57; will start 6 mo before; exp'd in organization, personnel, purchas'g; will be appoint'd dept hd on opening; lge city; MW. (c) Group 10 specialists w/own 50 bed hosp; Calif. (d) Bus Mgr; vol gen hosp 130 bds nr Pittsburgh; complete chge all acctng. (e) 12 man grp estab '26; req's minimum 2 yrs clinic exp. twn 50,000; W. (f) Ass't Mgr; 16 man grp estab '48; new bldg; pref w/coll degree & acctng background; minimum $350, increases $550; Calif. (g) Ass't Bus Mgr; 15 man grp; Bay area, Calif.

ADMINISTRATIVE EXECUTIVE POSTS: (a) Hosp accountant to serve as consultant to lge hosp organization; some tch'g, travel; $8-10,000; univ city; MW. (b) Accountant; dept staffed by Comptroller, 2 accountants; lge gen hosp; minimum $3-$400; Bay area, Calif. (c) Accountant; new gen hosp fairly lge size; delightful res suburb of Chgo. req's hosp exp. (d) Comptroller; with hosp exp; vol gen hosp lge size; New England. (e) Ass't Comptroller; new post; pref C.P.A. able assume comptrollers post; vol gen hosp 350 beds; univ city; MW. (ee) Comptroller & credit Mgr; full chge all finance, C&C; fairly lge gen vol hosp; Fla. (f) Credit Mgr to assist Comptroller; vol gen hosp 450 beds; city 200,000; MW. (ff) Personnel Dir; new post; male or female; exp'd; vol gen hosp 300 beds; univ city; Mid S. (g) Ass't Personnel Ofc; tch'g hosp 500 beds; about $5000 increasing to $7000; city 170,000; MW. (h) Director, Public Relations; vol gen hosp 400 beds, med schl affil; E. (i) Purchasing Agent; gen hosp 200 beds; if exp'd, $450; Calif. (j) Purchasing Agent; gen hosp 100 beds; Colo. (k) Purchasing Agent; w/degree in bus adm; some adm duties; 200 bed gen hosp; if exp'd, $450; MW. (l) Ass't Buyer; male or female; very lge med schl affil hosp; $5000; univ city: New England.

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ASSISTANT COMPTROLLER: Middle West. Newly created position. Require general knowledge of insurance, investments, judgments, costs, credits and collections, analysis of financial data. 325 bed hospital.

MEDICAL TECHNOLOGISTS: (a) Middle West. 200 bed hospital in city of 150,000. To $350. (b) South. 200 bed completely air conditioned hospital. Large modern laboratory: 7 technologists. $300-350. (c) Southwest. Small private clinic. 2 full time technicians and X-ray technicians. $350. start-increase 6 months to $400. (d) East 300 bed hospital; school for medical technologists. City of over 75,000. $375. (e) Middle West. 150 bed hospital near Chicago. $300-$400. (f) Middle West. 250 bed hospital. Complete supervision of laboratory. $350 up. (h) Southwest. 250 bed new, modern hospital in famous resort city. $300-$350. (i) East. 60 bed hospital, near N. Y. City. $325-$375.

DIETITIANS: (a) Assistant. California. Close to San Francisco. 150 bed hospital. Excellent opportunity for a therapeutic dietitian who would like to gain some experience in administrative procedures. $350. (b) Chief. California. 250 bed hospital. 50 employees in dept. $6000. (c) Chief Therapeutic Dietitian. Southeast. University hospital. $4000. (d) Food Service Manager. Middle West—near Chicago. Department being completely reorganized. (e) Chief. Middle West 140 bed hospital in college town. 24 employees in department. $6000. (f) Therapeutic—some teaching. Middle West. 200 bed hospital in city of 60,000. $375 minimum. (g) Therapeutic. Middle West. 100 bed hospital. 11 employees in department. $385-$425. (h) Administrative. South. 230 bed hospital in large city—well known medical center. $5000. (i) Southwest. 150 bed hospital. Complete charge of diet kitchen also teach nutrition and diet therapy to student nurses. $350 up. (j) Head. East. 57 bed general hospital—a building program is under way. $4800. (k) Therapeutic. East. 570 bed hospital in city of 30,000. Duties: Therapeutic diets and instruct outpatients. (l) Assistant. East. 300 bed hospital built in 1953—Very modern, in city of 300,000. $400. (m) Administrative and therapeutic. South. 250 bed hospital. 51 employees in dept. (n) Pacific Northwest. 150 bed hospital. Kitchen is entirely new, meal pack service used. Department is well staffed; have an excellent chef. $4800.

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Miss Elsie Dey, Director

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PURCHASING AGENT — PHARMACIST: 60 bed hospital, Ohio. (b) Public Relations Director, East.

COMPTROLLER: 200 bed hospital, Pennsylvania. (b) 260 bed hospital, suburb Philadelphia. (c) 135 bed hospital, New York State. (d) Accountant; new hospital, Ohio.

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COMPTROLLER: Degree, Ohio State University. 6 years Auditor. 3 years Chief Accountant, 500 bed Ohio hospital. Available. Private clinic considered.

ASSISTANT ADMINISTRATOR: Degree, Hospital Administration, 1953. 1 year Personnel Director; 2 years Assistant Director. 200 bed hospital, east.

EXECUTIVE HOUSEKEEPER: Course, Michigan State University. 4 years Assistant, 300 bed New Jersey hospital. Housekeeper, 3 years, 200 bed New York hospital.

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Suppliers News

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John F. Lorch

F. J. Pollnow

BECKER, BEN—Appointed advertising and sales promotion manager for the S. Blickman Company in Weehawken, New Jersey.

BROWN, LINWOOD F.—Promoted to the newly created position of marketing manager for the General Foods Corporation in White Plains, New York.

CONDON, NORINE—Joined the Consumer Service Department of the American Institute of Baking in Chicago, Illinois. She was formerly dietitian at the Little Company of Mary Hospital in Chicago, Illinois.

DIRKS, RICHARD—Appointed general sales manager of the Blue Jay Sales Division of the Kendall Company in Chicago, Illinois.

GROSS, MALVERN J.—Appointed vice president of Tracerlab, Inc., and general manager of the Keleket X-ray division of the company. As general manager of Keleket, MR. GROSS will be responsible for the engineering, development and marketing of x-ray products, and operations of Keleket's world-wide sales organization.

HOPWOOD, DAVID J.—Appointed sales promotion and advertising manager for the General Foods Corporation of White Plains, New York.

HUTCHINSON, PAUL C.—Appointed director of sales of the instrument division of the Perkin-Elmer Corporation of Norwalk, Connecticut.

LORCH, JOHN F.—Appointed national sales manager for the General Foods Corporation of White Plains, New York.

POLLNOW, FRANK J.—Appointed president of the Vestal Laboratories, Inc. in St. Louis, Mo. He was formerly executive vice-president of the firm. He succeeds his father, FRANK J. POLLNOW, SR., founder of the Chemical Specialties Manufacturing Company, who will continue active as chairman of the Board.

SCOTT, LEONARD A.—Appointed sales manager of the South Central division of the Hill-Shaw Company in Chicago, Illinois.

SLATTERY, RICHARD J.—Appointed sales representative in the Iowa-Nebraska Territory for The Miller Company of Meriden, Conn.

TACY, CURT—Appointed Hospital Field Sales Manager for the Bauer & Black Corporation, with headquarters in Chicago, Illinois.

TIERNEY, TOM—Appointed western hospital district manager for Bauer & Black Corporation in Chicago, Illinois.

VAILL, RICHARD A.—Appointed western regional manager for the Edwards Company, Inc. of Norwalk, Conn. He was formerly district manager at San Francisco, California.

VOLCKMANN, WALTER F.—Appointed sales promotion and advertising manager of General Foods Corporation's Institutional Products division, having served the company since 1930.

L. A. Scott

R. J. Slattery

Curt Tacy

Tom Tierney

R. A. Vaill